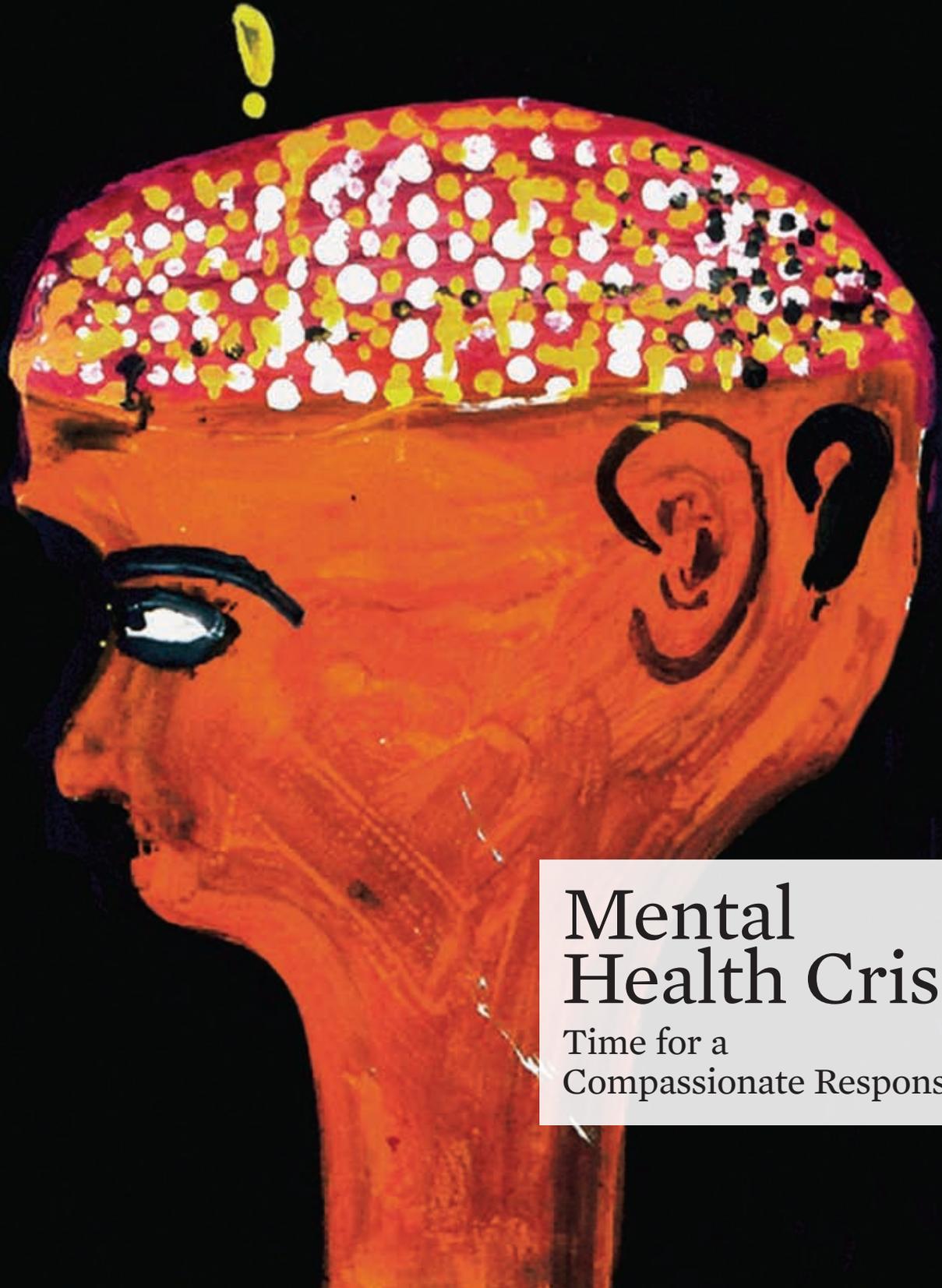


CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO

FALL 2009

network



Mental Health Crisis

Time for a
Compassionate Response



SUE GOODWIN, *MY FAVOURITE THINGS*
(ACRYLIC ON BOARD)



Contents

FEATURES

- 5 **Here's Your Hat, What's Your Hurry?**
When mental illness visits the ER
- 9 **From "Emergency Couch" to Emergency Care**
Ensuring access to ER alternatives for people in mental health crisis
- 14 **Still Waiting...**
Ontarians speak out for better access to treatment
- 16 **Engaging Youth in Crisis: Keira's Story**
Mindyourmind inspires young people to reach out for support
- 18 **First Responders**
Police as front-line mental health workers
- 22 **Tip Sheet**
How to respond to someone in a mental health crisis
- 23 **Invisible Caregiver**
A father's story of caring for his mentally ill daughter
- 26 **Family Support in the ER**
A little information and a little advocacy can go a long way
- 27 **Warm Lines**
Preventing crisis, one call at a time

DEPARTMENTS

- 3 **Guest Editorial**
Caring for our most vulnerable is the true measure of a civil society
- 28 **Research Snapshot**
SEEI crisis studies
- 31 **The Gold Standard**
Responding as a system to mental health crisis

network

FALL 2009 VOL. 25 NO. 2



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

EDITORIAL COMMITTEE

Wendy Fields, Editor
Margi Clarke
Judith Coulman
Michelle Gold
Joan Jones
Scott Mitchell
Gilles Myner

CONTRIBUTORS

Diana Ballon
Uppala Chandrasekera
Christine Garinger
Michelle Gold
Vani Jain
Sandi Kendal
Pam Lahey
Barbara Neuwelt
Paul Quinn
Nandini Saxena

DIRECTOR, KNOWLEDGE TRANSFER

Scott Mitchell

ADMINISTRATIVE ASSISTANT

Susan Macartney

DESIGN

Soapbox Design Communications Inc.

OUR MISSION

The Canadian Mental Health Association, Ontario develops and provides public policy advice that promotes mental health and improves the lives of people living with mental illness.

Network magazine is published 2 times each year.

© 2009 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 416.977.2813

E-MAIL network@ontario.cmha.ca

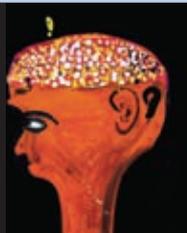
WEBSITE www.ontario.cmha.ca

Printed in Canada by Pulsar Printing Ltd. ISSN 1181-7976

LOOKING FOR THE CALENDAR? VISIT WWW.ONTARIO.CMHA.CA/EVENTS

Re: Cover

Normand Hébert, *J'ai mal à la tête* (gouche et collage sur carton), 1994. Collection Les Impatients. Reproduced by permission. This work appeared in the 2003 exhibit *Mindscapes/Vues de l'esprit*, Ottawa.



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



Caring for Our Most Vulnerable Is the True Measure of a Civil Society

Thirty years ago, efforts to deinstitutionalize Ontario's psychiatric patients combined with a lack of community resources landed thousands of men and women into Toronto's downtown boarding homes, grubby rooming houses and crumbling apartment buildings.

By the late 1970s, thousands of men and women struggling with lifetimes of addictions and mental illness were living in poverty and often desperate conditions in Toronto's core. It was within this context that Toronto's mayor, Art Eggleton, commissioned the "Mayor's Action Task Force on Discharged Psychiatric Patients" (The Gerstein Report), chaired by Dr. Reva Gerstein. The task force had representatives from the major stakeholders including hospitals, hostels, community legal services, community mental health programs and psychiatric survivors, including activist Pat Capponi who had the personal experience of living in one of Parkdale's notorious rooming houses.

The final report of the task force was produced in 1984 and with it came 27 recommendations aimed at transforming the living conditions of those struggling and surviving with chronic mental illness. One of the key recommendations was for the establishment of a Toronto community crisis

centre. In 1989 the Ontario Ministry of Health and Long-Term Care (MOHLTC) approved funding for the Gerstein Crisis Centre to be established in downtown Toronto.

At our official opening in February 1990, Dr. Gerstein said, "We who consider ourselves as civilized should pause and think for a moment. A great city such as ours is not judged by its beautiful buildings, its clean streets, its subway system or its harbourfront. The true measure of a civilization rests upon how it cares for its vulnerable members." It has been Dr. Gerstein's vision and her continued guidance that informs our work, first as chair of the board from 1989 until 2006, and since then with her generous counsel and advice.

The Gerstein Centre's comprehensive crisis response model — which includes a mobile crisis team, a safe beds program and crisis support phone line — is unique in Ontario. Numerous mental health crisis response initiatives have since emerged across the province. Some of these innovative programs — developed in response to specific community needs, geography and population size — are profiled in the pages that follow in this issue of *Network*. What distinguishes the Gerstein Centre from these other initiatives is its capacity to offer multiple mental health crisis response options within one organization.

The centre is an alternative to hospitalization — and can be a diversion from the emergency room — when the individual either doesn't want or doesn't need a hospital admission. People in mental health crisis can self-refer or be referred to the centre. People learn about us in many ways — by word of mouth, through our outreach to underserved



GERSTEIN CRISIS CENTRE, TORONTO, ONTARIO

PHOTOS BY MARK D'AGUILAR

areas, and through established relationships with the major Toronto hospitals. We refer to everyone and receive referrals from everyone. Over the last 20 years we have forged good reciprocal working relationships with health and social service agencies across Toronto.

The nature of the crises dealt with at the centre are more severe today than when we first opened our doors, in part due to hospital funding cutbacks for inpatient psychiatric care. Rather than focusing on the diagnosis, we look at presenting problems and work with the individual to seek realistic, practical solutions to the immediate crisis.

From the very beginning, the Gerstein Centre actively found ways to include psychiatric survivors in all aspects of the centre's operations. We sought out and used consumer/survivor businesses to provide needed services: A-Way Express (couriers), Fresh Start (maintenance), Able Enterprises (furniture), Raging Spoon (special events catering), and Green Thumb Enterprises (gardening). We expanded consumer/survivor participation on the board of directors, from one representative to a minimum of one-third board representation, and hired psychiatric survivors as community crisis workers, working as equals on our crisis team.

In the fall of 2007 we were able to secure funding from

the MOHLTC to create a second Gerstein Crisis Centre in downtown Toronto. The site was found and developed by community-minded businessmen Bill Munro and Ken McGowen, who renovated the site for our needs. Together we created a home-like setting with nine beds for men and women with mental health issues who are also in conflict with the law, and five beds for women who have mental health issues and are experiencing homelessness. The nine beds are part of the Toronto Mental Health and Justice Short-Term Residential Crisis Bed network that includes CMHA Toronto Branch, Reconnect Mental Health Services and COTA Health. The network has been a real collaborative effort with the generous sharing of knowledge, experience and community connections to benefit the psychiatric survivors that we are here to help.

As we look back on the past 20 years, we can see many improvements in the lives of psychiatric survivors in Toronto, yet there is still a long way to go. If we listen to the strong voice of the psychiatric survivor community — to those with lived experience — we can make positive changes to the mental health system.

Paul Quinn is executive director of the Gerstein Crisis Centre.

by
Pam Lahey

Here's your What's your hurry?

WHEN MENTAL ILLNESS
VISITS THE ER

GOMERS — Get 'em out of my emergency room stat — that's the demeaning label often slapped on people with mental illness who come to an emergency room (ER) seeking help. It's shorthand for "you're not welcome here." And it's an effective one.



ften people who come through the ER doors with a mental health issue are there in a last-ditch effort to get assistance with psychosocial problems. In the absence — or lack of awareness — of alternative community care options, the hospital

ER can become the default mental health provider. While mental health conditions account for nearly 132,000 ER visits per year in Ontario, evidence indicates that those seeking help do not receive care at the same level of urgency provided to individuals with physical health issues.

The past two decades have seen some progress on this front. In the early 1990s, a Calgary ER pilot project examined the provision of care for persons with psychiatric conditions. Best practice guidelines were developed, and some were adopted as national standards for ER care by the Canadian Council on Health Services Accreditation (now Accreditation Canada). As a result, persons with mental health issues are afforded some basic accommodations such as a private space for consultations. In spite of this progress, negative attitudes — manifested in discriminatory behaviours — still prevail.

Julia (not her real name) has been living with anxiety, attention deficit disorder, and complex post-traumatic stress disorder since her early teens. At age 21, she's been in and out of the ER many times for mental health crises. In the past year, numerous suicide attempts have made her visits more frequent. In the absence of a family physician or other community resources, she turned to the ER for help. "I went to the ER because I wanted to get my life together." Instead of getting the treatment that she needed, she felt neglected and her problems discounted. "When I come into the ER I feel like 'oh here we go again'... I feel like a burden to them. They treat me like that."

Sadly, Julia's experience is not uncommon. Heather Stuart, an anti-stigma researcher with Queen's University, explains that there's plenty of anecdotal evidence that echoes Julia's experience. "We don't have a lot of systemic data ... but what we do know is they [people with mental health issues] don't have a good time in emergency rooms. They are treated inequitably and have inordinately longer wait times than others." Stuart believes that this happens because hospitals have a "blood and broken bones first and mental health second" mindset. Stuart observes that "this mindset and the resulting discrimination that persons with mental health issues face may not be a deliberate attempt to discriminate, but may instead be 'just the way the system is set up.'"

She suggests that addressing gaps in research may help to identify the root causes of discrimination. "One of these gaps," Stuart notes, "is the lack of documentation of the ER experience from the consumer perspective."

The Central Local Health Integration Network (LHIN) — responsible for 25 communities spanning the northern section of the City of Toronto, most of York Region, and a part of south Simcoe County — has started to fill this gap through a recent pilot project in the "905 communities" north of Toronto. Five emergency rooms were the focus of a qualitative study that explored options for enhancing service delivery to persons presenting with mental health problems. Funding was also provided to develop educational workshops to address mental health discrimination in ER settings.

The Central LHIN Consumer Survivor Network received some of these funds to organize and conduct a series of seven town hall meetings as a way of collecting information from mental health consumers on what is working and what needs to be improved in ER care. Meetings were held between November 2008 and March 2009, allowing organizers to hear the views of 160 mental health consumers. This study yielded a number of findings that validated previous anti-stigma research undertaken on this topic from a non-consumer perspective.

Theresa Claxton, coordinator of the Central LHIN Consumer Survivor Network, shared these findings with *Network* magazine. The number one barrier to accessing care is attitudinal. "Instead of the ER being a safe haven and gateway to a cure," says Claxton, consumers "were treated as unwanted burdens." Claxton explains that the triage system is set up to determine how immediate someone's level of need is considered to be. "The way the system is set up now," Claxton continues, "if it is a psychiatric crisis, the person can wait for as long as they can possibly wait!"

In the current system all ER patients are seen by an ER physician even if their presenting problem is not a physical condition. This process means that people coming in for

Peer workers — also known as peer navigators — can act as a resource (e.g., connecting consumers to aftercare community agencies) or provide direct support to persons in crisis while they wait to be seen by a doctor.

a mental health crisis wait for hours just for the doctor to say “Okay, we’re going to refer you to a psychiatric team.” Claxton adds, “It’s very frustrating ... this experience has resulted in many consumers not waiting to be seen, and if they are seen, not following through on the treatment that was suggested.”

Instead they often choose to deal with the crisis themselves. “They would rather deal with things themselves than have to go through that again as it [the experience] increases their feelings that they aren’t worthy of treatment.”

Julia’s experience led her to the same conclusion. During her last visit to the ER, she was sent home four hours after overdosing, in spite of the knowledge that she would be unsafe: “They questioned me while I was high on the medication. They asked me, ‘Do you feel safe to go home?’ I said no. They asked my mother, ‘Can you keep an eye on her?’ and she said ‘No, because I have to work.’ They asked my boyfriend and he said ‘No ... if she is going to do something she is going to do something.’ ... They asked me again if I would be safe. I said ‘No, if I go home I will finish off the bottle,’ but they sent me home anyway.”

Julia decided to face the consequences of her overdoses rather than subject herself anymore to the treatment she received in the ER. “I will absolutely not go back. I don’t know what I would do ... I would rather suffer than go back to the ER.” Fortunately, Julia’s story ends well. An employment specialist connected her with a community mental health resource that now provides her with the counselling she needs to stay healthy.

Experts agree that creating a system in which non-medical emergencies bypass the laborious triage process would free up staff time and address patient needs more quickly. Stuart concurs: “Some parts of the world are thinking about [operating] specific mental health emergency facilities so people with mental health issues can be dealt with immediately.”

London Health Sciences Centre, located in London, Ontario, is an example of one such facility. In May 2001, the centre implemented a population health triage process designed to assess persons with mental health issues outside of the general triage process. This new streamlined approach allowed the triage nurse to transfer the patient directly to a psychiatric nurse. The process was reported as being beneficial by both staff and patients; wait times were decreased and patients were referred to more appropriate

aftercare resources in the community.

The United States is in many respects ahead of Canada in developing innovative approaches aimed at improving the experience of ER care for mental health consumers. One such solution is the use of peer workers. Peer workers are not a new concept, but using peer workers in an ER setting is. Peer workers — also known as peer navigators — can act as a resource (e.g., connecting consumers to aftercare community agencies) or provide direct support to persons in crisis while they wait to be seen by a doctor. In Maine, 50 percent of people who visit the ER in mental distress are seen by a peer navigator. Claxton likes the term “peer navigator.” “The term fits well. It’s about someone already in the system that knows the way around and shows others how to connect to services, and what the process is.”

A few Canadian cities have started to think creatively about how to provide better care when someone experiencing a mental health crisis shows up at their local ER. The Region of Waterloo is one such place. Alan Strong, Recovery Coordinator at the Self Help Alliance in Waterloo and Wellington, says there is “an appalling lack of resources in this area.” He calls peer navigation a novel concept — a positive way to deal with the issues people face in the ER. The Self Help Alliance, led by Kathy Briggs, in partnership with CMHA Grand River Branch, has been actively working towards making peer navigators part of the ER system of care.

The Self Help Alliance has political will on its side. The provincial strategy on ER wait times has prompted hospitals and community providers to consider innovative solutions. CMHA Grand River Branch and the Self Help Alliance, for example, are engaged in negotiations with Grand River Hospital to place peer navigators in the ER.

Psychiatric wait times are a key concern in the mental health community. Research has shown that persons with mental illness wait on average two hours longer than other patients to see an ER physician. Findings from the Central LHIN pilot project also identified longer than average ER wait times. “Longer wait times for persons with mental illness further compound existing issues,” explains Claxton. “They will wait for hours before being seen and that can escalate any kind of feelings that people are having.”

While having peer navigators work in the ER may not directly result in decreased wait times, these peer specialists can be instrumental in helping the person in crisis to manage escalating symptoms that often result from waiting an



People with mental health issues “don’t have a good time in emergency rooms. They are treated inequitably and have inordinately longer wait times than others.” Hospitals have a “blood and broken bones first and mental health second” mindset.

*Heather Stuart,
Queen’s University*

“When I come into the ER I feel like ‘oh here we go again’... I feel like a burden to them. They treat me like that.” *Julia*

inordinately long time. Strong contends that offering a person in crisis someone else to speak with while they wait out their time — someone who understands their struggles and can help them connect to other helpful community resources — ultimately makes the experience a more positive one. Claxton is hopeful that the peer navigator model can be brought to the Central LHIN. Peer support training is vital for change to begin to take place. And this change looks promising. The Central LHIN funded a week-long peer support training session in August 2009 which prepared peer navigators for ER work. Hospital negotiations are the next step.

In theory peer navigators seem like an innovative enhancement to ER care. Stuart agrees that having peer navigators in the ER is a good idea, but wonders if the lack of documented research attesting to the value of such a service will prevent it from happening. Strong is facing that issue now. “Everyone says it’s a good idea,” observes Strong. “It’s just how to make it work.” There are a lot of legitimate questions

to work out, but Strong emphasizes that the Region of Waterloo is open to it. “They are just moving cautiously.”

Educating ER staff about how to effectively care for those in mental health crisis is a longer-term goal. The Central LHIN pilot project has also begun to tackle this issue head on. Mental health consumers were selected to train ER staff on how to care for individuals in mental health crisis. The training helped to address ER workers’ preconceived fears and notions about patients with mental illness. While a formal evaluation of the training has not been completed, the initial feedback was encouraging. Trained staff have said, “I never thought of it that way. It has given me a new perspective and I will consider this in changing my practice in dealing with people with mental illness.”

The seeds of change have been planted. For many this change can’t come soon enough, and must be seen as a necessity — not a nicety. In the words of Michael Wilson, the Canadian ambassador to the United States, whose son, Cameron, suffered severe depression and committed suicide, “We should care for the mentally ill as a matter of good conscience and good public policy.” If some regions in southern Ontario are any indication, good public policy will be coming soon to an ER near you.

Pam Lahey is a policy analyst at CMHA Ontario.

Proposed **ER GUIDELINES** *for Patients with a Mental Illness*

P 1.0 The examination and interview process and space are adequate for the safety, security, and privacy of patients and staff.

P 1.1 There are enough private interview rooms available to ensure privacy during interviews in most situations.

P 1.2 Interview rooms are secure.

P 1.3 Security staff are available on a timely, as needed, basis.

P 1.4 There is a policy in place governing the use of restraints.

P 2.0 There is a client/patient/family rights policy that defines its application to mentally ill individuals.

P 2.1 Information on rights is provided to the patient.

P 2.2 These rights are provided in a timely manner.

P 2.3 There is a policy whereby an interested second party is consulted when the patient’s mental illness interferes with the understanding of these rights.

P 2.4 There is a process for obtaining consent on behalf of a patient when mental illness interferes with understanding of the intervention being offered.

P 2.5 There is a process for deferring the above provisions in emergent cases.

P 2.6 There is a process for patients and families to voice concerns about rights violations.

P 3.0 Staff will be available who have competence in the management of mental health emergencies.

P 3.1 Staff will be available who are qualified to manage mental health emergencies.

P 3.2 In-service training is provided to fill any gaps in staff skills.

P 3.3 Staff will have acquired a “sensitivity” to mental illness.

P 4.0 The quality of services to psychiatric patients will be evaluated.

P 4.1 There is information on whether wait times for psychiatric patients differ from those with other illnesses or conditions.

P 4.2 Information on patient and family service satisfaction is gathered.

P 4.3 Information is gathered on the quality of treatment provided to ER psychiatric patients.

Core Recommendations from the World Psychiatric Association (WPA) Anti-Stigma Work, presented at the first International Congress on Reducing Stigma and Discrimination because of Schizophrenia, WPA, Leipzig, September 3, 2001.

from
“emergency
couch”
to
emergency
care

*PROVIDING HEALTH
CARE OPTIONS
TO PEOPLE IN MENTAL
HEALTH CRISIS*

by Sandi Kendal



When the Ministry of Health and Long-Term Care

launched Health Care Options, a website that helps people find local walk-in and after-hours clinics, urgent care centres, family health teams, and general practitioners — care providers that offer an alternative to hospital emergency rooms — the press release explained that “Ontarians can now find health care close to home with the click of a mouse.”

However, for someone in a mental health crisis, health care services tend to be few and far between, particularly on evenings or weekends. Even in communities where mental health services may be available, knowing where to turn can be confusing. The hospital emergency room (ER) often becomes the default destination for immediate care.

When Leila was in her late 20s, she experienced a series of psychiatric crises in public places, each one involving a police escort to the ER followed by long in-patient stays. Over time, Leila began to think of the ER as the best place to get the help she needed. It was where she was first diagnosed with a serious mental illness, and visiting the ER was the only strategy she knew to access care to manage her symptoms. “There were times when I was ill that I chose to go to the hospital. I wanted to be in the hospital. I felt that a part of me needed help from the hospital system and I had no other option to get into the hospital except through the ER.”

“There were times when I was ill that I chose to go to the hospital. I wanted to be in the hospital. I felt that a part of me needed help from the hospital system and I had no other option to get into the hospital except through the ER.” *Leila*

Emergency rooms — noisy and chaotic places — are often maligned as inappropriate settings for care for people in mental distress. They’re the antithesis of the calming environment that many assume is necessary to reduce stimulation and de-escalate a crisis. Ironically, the ER serves as a frequent entry point into the mental health system and into acute psychiatric in-patient care. Emergency departments across Ontario are struggling to respond to the demands created by this default role.

When ER Is the Right Option

With a picturesque view overlooking Lake Ontario in Toronto’s west end, St. Joseph’s Health Centre is situated in a neighbourhood characterized by one of the largest concentrations in Canada of people with serious and persistent mental illnesses. The hospital’s busy ER is also the most active emergency department in the Greater Toronto Area for psychiatric needs. In response to this high need, the hospital established an Emergency Psychiatric Team (EPT) — a psychiatric consultation team staffed by an on-call psychiatrist, crisis workers and a case manager. Last year, the EPT saw 2,998 mental health visits, with no less than 200 people requiring service each month.

Dr. David Gotlib, medical director of the EPT, and Shirley Pullan, patient care manager, explain: “The people we see in the emergency are really, really sick. They really need to be here. Oftentimes they are brought to the ER by concerned community support workers in housing or other programs who have no other access to psychiatric assessments for their clients in acute crisis.” And often, similar to Leila’s experience, the EPT sees people when they become extremely ill for the first time and have no community supports.





“Usually something has happened in an individual’s life — some life circumstance leading to the need for support. We share all available resources and make relevant referrals on their behalf that can support them after they leave our services.”

Dee Tyler, Distress Centre Niagara

Providing alternative crisis options for people who need intensive support requires more than simply making *any* services available in the community — those services have to meet people’s level of need, explains Dr. Gotlib. “To say that you want [alternatives to the ER] is to say that you want more intensive resources available immediately in the community. This is different than saying ‘they don’t really need to be in the ER.’ They need to be in the ER because what they need isn’t out there. Get what they really need out there, and then they won’t be coming. That’s not diversion. That’s putting the care in the community, helping the community workers and the case managers access the medical and psychiatric backup to support their clients.”

Individuals in St. Joseph’s ER who are experiencing mental distress — but do not require in-patient admission — are provided with immediate EPT case management services. “[The case manager] is an incredible resource for the team and for our patients,” explains Dr. Gotlib. “She’s improved the lives of those she’s been able to connect to programs.”

Are There Any Alternatives to the ER?

While the ER may be the right health care option for some individuals experiencing a mental health crisis, not everyone who comes to the emergency department requires the same intensity of service. The population served by St. Joseph’s Health Centre includes a subgroup of people with severe and chronic mental illnesses, but the overwhelming needs of those patients for acute in-patient and intensive care represent one extreme end of the spectrum of ER usage patterns.

Only 18 percent of Ontarians who visit an emergency department for mental health reasons are admitted into hospital. The vast majority of people in mental distress who visit ER could benefit from alternative health care options — if those options were readily available. For many people in crisis, ER is the place they end up because there’s nowhere else to go.

In some regions, service providers have come together to develop coordinated or comprehensive crisis response systems such as mobile crisis teams, but these are organized at the local level based on local capacity and only occur in pockets across the province. In the majority of communities, there are few options for 24-hour-a-day mental health care outside of hospital walls.

The ER may also be the only place that individuals know where they can access certain services such as prescription renewals, particularly in areas underserved by family physicians or psychiatrists. Furthermore, the ER might be the only option when people lack access to basic health promoting services and supports. One London, Ontario hospital found that up to 13 percent of its psychiatric emergency room visits were influenced by population health needs such as lack of access to adequate food and shelter, or in response to financial or legal circumstances. These visits are sometimes referred to as “emergency couch admissions.”

While desperate measures may bring in visitors seeking non-medical types of support, the ER is not necessarily well connected with, or in the business of making referrals to, social and community services. Moreover, oversaturated and overloaded health services across the continuum of care have been known to adopt

a disjointed “treat ’em and street’em” approach that addresses the immediate symptoms but lacks capacity, resources, time, or knowledge to connect patients with “upstream” health prevention and promotion services that can help with basic needs such as shelter, income, and other social determinants of health.

Innovative Models of Crisis Prevention and Response

Some communities in Ontario have examined alternative ways of providing care to people in mental health crisis so that the ER is not the default choice. Others have explored ways of providing preventive support as a means of reducing the number of people who go into a crisis state of mind in the first place. One such program, called Community Crisis Care, was developed in the southern Ontario communities of St. Catharines, Niagara Falls and Welland.

Community Crisis Care — the product of a partnership between the Canadian Mental Health Association,



“ER staff typically don’t have time to sit with someone in crisis. Yet ... it’s when clients are able to talk that they calm down, that they are able to see things clearer, articulate what they want, and make choices to resolve their crisis.”

Mary Barzyk, Community Crisis Care

Niagara Branch, the Niagara Health System and the Niagara Distress Centre — has been placing dedicated crisis workers into emergency departments since 1994. Now in its fifteenth year of operation, Community Crisis Care sees approximately 4,000 people at its three hospitals in a given year, and fields an additional 1,000 telephone calls from people in distress.

Originally conceived as a service that would give people choices for support in a crisis situation, the program lacked physical space to locate itself in the community. The only possible locations for this program were situated in the emergency departments of three hospitals. As a result, the program’s scope became narrower, to fit with hospital policies and resource limitations. On the upside, individuals arriving in ER in mental distress were now given the option of seeing a crisis service worker upon admission. It was discovered that this option could lead to better care for individuals in mental distress.

Mary Barzyk, manager of Community Crisis Care, and Dee Tyler, executive director of the Niagara Distress Centre, explain: “They get time, the time that they need, for someone to be patient with them, not rush them. ERs generally have a steady stream of people coming through their doors, so ER staff typically don’t have time to sit with someone in crisis. Yet a lot of times, it’s when clients are able to talk that they calm down, that they are able to see things clearer, articulate what they want, and make choices to resolve their crisis.”

Also importantly, people get seen in a timely manner. Crisis workers aim to meet with individuals within one hour of their arrival at the ER. Depending on the number of individuals waiting for a crisis worker, the wait time may be even shorter.

“People default to the hospital when they need crisis care,” says Barzyk. “We need to change a whole region’s way of thinking to divert people from emergency rooms.” In the meantime, by providing an alternative health care option to ER services within the hospital walls, Community Crisis Care is bringing a community option into a setting that people instinctively turn to for help. Even though it’s located on hospital property, the service is slowly being recognized as an alternative to the ER. Some individuals in crisis have been found bypassing the ER triage altogether, and heading straight to the crisis office for support.

Community Crisis Care links users to broader community services that can provide ongoing support and resources to help them address the issues that contributed to the crisis in the first place. Barzyk and Tyler explain that generally their clients have come seeking crisis services in response to a life-stressor. “Usually something has happened in an individual’s life — some life circumstance leading to the need for support. We share all available resources and make relevant referrals on their behalf that can support them after they leave our services.”

“To say that you want [alternatives to the ER] is to say that you want more intensive resources available immediately in the community. This is different than saying ‘they don’t really need to be in the ER.’”

*Dr. David Gotlib,
St. Joseph’s Health Centre*

“The best thing I can do for myself is to call the distress centre. I use them so I don’t have to go to the hospital. When we’re talking about the mentally ill, all we maybe need is to talk to somebody.”

Leila

Community Crisis Care is connected with CMHA Niagara Branch’s short-term residential crisis support program. This “safe bed” program provides a non-medical alternative to a hospital bed. Clients stay an average of three to five days, while program staff work with them to problem-solve and resolve their distress. Often this means making linkages to additional supports such as helping people sign up for Ontario Works or other social assistance programs, finding them a family physician, dealing with legal or justice matters, or searching for suitable living accommodations.

Access and Awareness

Having a range of service alternatives to the ER for people in mental health crisis is essential. Equally important, these services must be locally available and readily accessible.

Community Crisis Care is aware that it is not set up to serve the needs of Niagara Region’s rural populations. People who live outside of the main urban areas have to travel long distances to arrive at any of the three hospitals that can connect them with a dedicated crisis worker. Rural hospitals that may be closer to home lack psychiatric services altogether, let alone specific crisis programs. For people living in these communities, their only options for crisis care may be up to an hour away.

Promoting widespread public awareness of service alternatives is vital. Leila has not been to the ER for over a year. Through her ER visits she became connected with a psychiatrist and outpatient programs. Through medication and a support system, she has come to a place where the ER is no longer a viable option for her. “I’ve been avoiding going back to the ER because of my progress. I go back and there’s no longer any progress. I want to have progress instead of copping out and going to the hospital. I want to keep this consistency of being well.”

What about Leila’s strategy when her illness symptoms return? She’s counting on the local distress centre. “The best thing I can do for myself is to call the distress centre. I use them so I don’t have to go to the hospital. When we’re talking about the mentally ill, all we maybe need is to talk to somebody.” Yet, it was only by luck that Leila was connected to the distress centre. Rather than through a referral or a public awareness campaign, it was through a friend. Although Leila lives in a large urban centre that provides a wide range of crisis services and supports, she had never before been connected to this alternative resource through her medical supports.

At the end of the day, no one solution will work to meet all people’s needs. People seek crisis and emergency care for a range of reasons. Few communities are able to support the full range of services to meet these diverse needs. In some communities, and for some individuals, the best crisis care option may indeed be closer than they think. For many others, the harsh reality is that the ER may be their only choice.

Sandi Kendal is a health systems analyst at CMHA Ontario.

fastFACTS

131,604

Total number of visits to an emergency room (ER) in Ontario for psychiatric reasons in 2007
(Source: Systems Enhancement Evaluation Initiative)

44,778

Total number of visits to an ER in Ontario for psychiatric reasons in 2007 by individuals with a concurrent disorder
(Source: Systems Enhancement Evaluation Initiative)

166,640

Number of service recipients who used community mental health crisis intervention services in Ontario in 2006/2007
(Source: Community Mental Health CDS Project, Ministry of Health and Long-Term Care)

2,634

Number of service recipients who accessed short-term residential crisis support beds in Ontario in 2006/2007
(Source: Community Mental Health CDS Project, Ministry of Health and Long-Term Care)

68.4%

Percentage of ER visits for mental health conditions that resulted in discharge home in Ontario in 2006/2007
(Source: Ministry of Health and Long-Term Care)

17.5%

Percentage of ER visits for mental health conditions that resulted in being admitted into an inpatient unit in Ontario in 2006/2007
(Source: Ministry of Health and Long-Term Care)

Still

Wait

Patience is a virtue, or so they say. But what does it mean to have to wait when it comes to the most important thing in the world — your health?

When Heather was first diagnosed with a mental illness, her family physician referred her to a local psychiatrist. The hitch was that she was placed on a one-year waiting list — a wait that actually ended up lasting three years. “Where else in the medical system would this be acceptable?” asks Heather. “Would a cancer patient be left to wait three years to receive chemotherapy or radiation therapy? No! We’d be outraged.”

Yet day after day, people with mental health problems in Ontario are forced to wait. They wait to see psychiatrists. They wait to access case management services. They wait in hospital emergency rooms. And most of all, they wait for the system to change so that it can better respond to their needs — a change even those who work in the sector have been waiting years for.

This year marks the fifth anniversary of the National Wait Times Strategy. When the strategy was established in 2004, all First Ministers agreed to make timely access to medical care a priority. Today, “wait times” is still a buzzword, and Ontario has seen improvements in priority areas including MRI/CT scans, cancer surgery and hip and knee total joint replacements. Wait times in the area of mental health, however, have stayed off the priority list.

Yet the evidence of need in this area is clear. This year’s Wait Time Alliance Report Card — which reports on progress made against the National Wait Times Strategy performance benchmarks — was the first to include wait times for people living with major depression. It reported that the median wait time to access psychiatric care following a physician referral was 5.7 weeks — two weeks longer

than the Canadian Psychiatric Association's maximum wait-time benchmark of 4 weeks. The 2008 Fraser Institute report "Waiting Your Turn" indicated a median wait time of 18.6 weeks from when a psychiatrist refers someone for specific treatment to when they gain access to this treatment — 4.5 times longer than what physicians deem to be acceptable.

When emergency room (ER) wait times were added to Ontario's Wait Time Strategy, the Schizophrenia Society of Ontario (SSO) used this as an opportunity to raise awareness of the needs of people with mental health issues, many of whom wait an inordinate amount of time in the ER. Indeed, in some high-volume ERs, people with mental illness can experience lengths of stay in the ER of up to 2.9 times longer than average.

In its 2008 discussion paper, SSO addressed the system issues which contributed to long ER wait times for this population, including insufficient access to programs and services in the community. Clearly, the problem does not end at wait times to access psychiatric treatment. People with mental illness are forced to wait in all other aspects of their care as well. For example, in spite of clear evidence of the benefits of supportive housing for people with serious mental illnesses, up to one-third of Ontarians are not able to access this type of service when they need it.

Waiting lists range from one to six years depending on the region.

But what does the issue of wait times really mean to those who experience the direct impact? In the fall of 2008, SSO held a series of community forums to hear from the grassroots level about barriers experienced in accessing treatment, services and

supports, and the solutions that they felt would have a positive impact in these areas. Over the course of visiting nine cities, we heard from more than 330 people — consumers, family members, service providers and members of the public — about the virtual wall that kept them from getting the assistance they needed. The frustration in participants' voices was evident as they shared stories of feeling lost, confused and most of all let down by the system that was supposed to help them. While the issues in each city varied slightly, the key theme that resonated across the province was the inability to access the services you need when and where you need them.

Part of the problem is that many of the core services consumers need to access are at — or close to — full capacity, meaning there is just no room to take on new clients. Even where services do exist, they are often underfunded or understaffed, leaving them unable to meet demand. For example, one person talked about cuts to her local Assertive Community Treatment team, which reduced its 24/7 availability in her area. Those in rural parts of the province talked about the complete lack of nearby services and the frustration of hearing about a great program elsewhere, but not falling within its catchment area.

So what are we going to do about it? How are we going to break down the walls that are preventing people with mental health problems from accessing the services and supports they need? There was no shortage of solutions presented by attendees at SSO's community forums. These included such concrete ideas as developing and enforcing a hospital protocol for addressing individuals who

present to the ER in psychiatric distress, evaluating programs that have been effective in one area to determine their applicability to other regions, and providing housing arrangements to individuals transitioning from the hospital into community.

System change is possible and must happen. People with lived experience must have their voices heard to ensure that the policies and strategies that affect those with mental illnesses are truly reflective of what they themselves need and deserve. Because consumers and families in this province should no longer be told to simply "take a number."

Vani Jain is manager of policy and community relations at the Schizophrenia Society of Ontario.

ing...

SPEAK UP: Improving Access to Treatment

In 2008, the Schizophrenia Society of Ontario (SSO) launched a three-year campaign to improve access to treatment. To encompass the broad range of services and supports needed by people with mental illness during their recovery process, the campaign defines "access" to include psychiatric treatment, community-based mental health services, and social supports such as income and employment. People with mental illness and their families face numerous barriers to accessing these necessary treatments, services and supports.

If you're concerned about these issues, SSO encourages you to take action! Join the Access to Treatment Coalition to receive updates on how you can help change the system for the better. For more information, visit www.schizophrenia.on.ca.

by Christine Garinger

Engaging *Youth* — IN — CRISIS:

Keira is a young woman in distress. She knows she needs to do something about her situation, but she's confused about her options.



Keira's
Story

Young adults often know when they need to do something, but are unsure of themselves and their choices and can be terrified of making a wrong choice. Throw in the cognitive issues, thought distortions, and the consequences of stigma associated with a mental illness and youth can become immobilized while important developmental opportunities pass by.

Keira's Story is an online game developed by mindyourmind, an award-winning, not-for-profit youth mental health engagement program in London, Ontario. In the game, players meet Keira, a young woman who has locked herself in her friend's bathroom. She is at the pinnacle of an unidentified crisis. She describes symptoms similar to anxiety or possibly panic, but could be indicative of PTSD flashbacks,



withdrawal from substances, or emotional dysregulation. The exact issue is left nondescript in order to allow a wide range of users to role play.

Players move the mouse cursor over the background to find objects to interact with and are led through steps in order to complete the game. The player chooses the order of the environments and options that Keira explores. The environments are Keira's own bedroom (represented by keys), a counselling office (symbolized by a cell phone), and the hospital emergency department (symbolized by a pill bottle indicative of self-harm or suicide urges).

Keira's Story delivers four key messages: you have choices in how you manage your issue and doing nothing is a choice; deciding to do something can feel risky; there are things you can do to cope and you can always learn new ways; when is it time to go to a hospital for help and what is that like?

Mindyourmind develops resources to reduce the stigma associated with mental illness and increase use of community support services, both professional and peer-based. The team behind mindyourmind is a unique blend of youth, clinical, technical and creative professionals inspiring young people to reach out, get help and give help using active engagement processes and technology. The website www.mindyourmind.ca is just one of those communication platforms.

Partnerships with stakeholders ensure that mindyourmind program content is relevant to its participants and end-users. In 2007, the London Mental Health Crisis Service and the Canadian Mental Health Association, London-Middlesex Branch, sponsored mindyourmind's Getting Help 2: Keira's Story. The digital options game was developed in response to gaps in knowledge identified by youth advisors during mindyourmind's focus groups. Youth had questions and apprehensions about what to expect if they visited a hospital emergency room or a counsellor's office. Giving information in a digital format with visuals they can relate to, along with an opportunity to role play, allows the player to learn in multi-dimensional ways that are meaningful for that indi-

vidual. Game creation was led by mindyourmind's Kyle Nau, game developer, and Christine Garinger, registered nurse.

The overarching goal of Keira's Story is to give young people information they need to access services during a time of distress for themselves or for a friend. A client and professional working side by side at a computer can role play and create extended scenes to address different challenges unique to the client's situation.

Keira's Story, along with a printable guide, can be found on www.mindyourmindpro.ca. Created as a companion site to mindyourmind.ca, the pro website includes coping tools, videos on topics related to working with youth, crisis planning tools, and information about using new technology. The website is now in beta, and registration is free. It was developed to provide innovative web-based and social media tools to enhance the practice of health care professionals, service providers and educators working with youth.

Engaging in play and focusing on a learning tool such as Keira's Story can be a transformative alternative to using only traditional talk-based support.

Christine Garinger, RN, BN, is the Pro Site and Education Coordinator at mindyourmind.



FIR
ST
RE
SP
ON
DE
RS

*Police as Front-Line
Mental Health Workers*

by
Uppala Chandrasekera

Someone called 9-1-1. The police quickly arrived on the scene. Leung was handcuffed, shackled and led away to the police station. “I didn’t know what was happening,” says Leung, 42.

He was not given any opportunities to explain himself. The police did not question him about the circumstances surrounding the incident, nor did they ask about his state of mind at the time. This negative interaction with the police has had a lasting effect on Leung. “I am now paranoid about the police,” he says.

Leung, a long-term client of the Mount Sinai Hospital Assertive Community Treatment Team (MSH ACTT) in Toronto, has been diagnosed with schizophrenia. A few years ago, while living in a boarding house, Leung witnessed an altercation between a male and female resident. Leung tried to intervene to help the female resident, but the situation only escalated. Leung felt threatened, provoked and *triggered*. He lashed out and struck the male resident with a plank of wood. Recalling

the incident, Leung says, “I felt really, really bad about that. I’m not a fighter.” During the incident, someone in the boarding house phoned the police.

“I knew that it was my fault and I was sorry. And I didn’t want them to bring the army. So I just put my hands behind my back and they just handcuffed me.” Leung was arrested, sentenced and served a few months in jail. “They could have talked to the lady [who had witnessed the entire incident] and found out from her exactly what happened because I didn’t know what was happening,” says Leung. He also wished that they had called his case worker from the MSH ACTT to assist him. What was lacking in this situation was a compassionate, coordinated response.

Although most people with mental illness living in the community never come in contact with the police, psychiatric emergencies do occur. Approximately 7 to 10 percent of calls to the police involve a mental health crisis. The person in crisis may reach out to the police for help. Family members may call the police as a way of getting proper care for their loved one. Sometimes, neighbours or strangers call the police when they feel scared by a person’s behaviour or, as in Leung’s situation, bystanders call the police when they feel that a crime has been committed.

In all of these cases, 9-1-1 is dialled, and law enforcement agents, by virtue of their role as emergency responders, are called upon to be the first responders to a mental health crisis. Policy and legislative changes over the past 30 years — the attempts to de-institutionalize Ontario’s mentally ill, the arrival of mental health reform, and the shift toward more community-based mental health services, coupled with recent changes to the *Mental Health Act* — have greatly expanded the role and authority of the police in responding to those in mental health crisis. Over the past decade, this trend has seen municipal and provincial police officers become the newest front-line mental health workers.

When the police encounter a person in crisis — often referred to as an “EDP”

(emotionally disturbed person) — they have the option of diverting that person into the health care system, rather than making an arrest. They may transport them to hospital, voluntarily or involuntarily. Under the *Mental Health Act* in Ontario, a police officer has the legal authority to detain someone and bring them involuntarily to a hospital for psychiatric assessment if they consider the person to be at risk of causing serious bodily harm to themselves, at risk of causing harm to someone else, or unable to care for themselves. In their role as front-line mental health workers, police officers are faced with the challenge of providing a compassionate response at times of crisis. A compassionate response is the ability to safely intervene in crisis situations. A compassionate response involves engaging in active listening and showing empathy to help the individual overcome their moment of crisis.

In some urban centres in Ontario, when the police dispatch receives a call regarding a mental health crisis, they have the option of contacting a mobile crisis intervention team (MCIT) for assistance. A large population density is needed to sustain full-time, around the clock MCIT services; therefore, MCIT programs are more common in large urban centres such as London, Ottawa and Toronto.

The Crisis Outreach and Support Team (COAST), an affiliate of St. Joseph’s Healthcare Hamilton, was one of the first MCITs in Canada, along with Car 87 in Vancouver. This innovative program, which brings together an interdisciplinary team of mental health workers and police officers, was developed in 1997 in response to several tragedies in the community involving individuals with mental illness.

“Our goal is to keep the person in the community,” says Sarah Burtenshaw, a mental health worker at COAST Hamilton and the Crisis Intervention Team Coordinator for the Hamilton and Niagara Regions. COAST operates 24 hours a day, every day, and provides two types of service: a 24-hour crisis help line, and mobile visits within the



SARAH BURTENSHAW (LEFT), MENTAL HEALTH WORKER, COAST HAMILTON, CRISIS INTERVENTION TEAM (CIT) COORDINATOR FOR HAMILTON AND NIAGARA REGION, AND PROVINCIAL CONSTABLE JAY EBERLEY, ONTARIO PROVINCIAL POLICE, CIT FACILITATOR, NORFOLK COUNTY

Hamilton community. The crisis line is used by individuals, family members, concerned community members and police officers who can gain access to information about mental health issues, resources, contact information, referrals and support during a crisis situation. Sometimes the caller is supported by phone, and sometimes the caller requires an in-person visit. According to Burtenshaw, “Many family members will call and say, ‘I have my son, he’s

COAST brings together an interdisciplinary team of mental health workers and police officers to assist individuals and provide a compassionate response during a mental health crisis. “Our goal is to keep the person in the community.” Sarah Burtenshaw

unwell, he’s down in the basement, he’s talking to himself ...’ Maybe this is his first episode of psychosis, and the family doesn’t know how to respond. ‘He won’t go see the family doctor, he won’t do *anything*, what do I do?’” This is the time for a compassionate response. This is the perfect time for COAST to show up.

COAST has two mobile crisis intervention teams: an adult team, and a child and youth team. Each team consists of a multidisciplinary group of mental health workers — nurses, social workers, child and youth workers and occupational therapists — and four full-time police officers dedicated to the program. A mental health worker and a police officer pair up to attend each mobile visit. “We try to see people in their homes because it gives us insight into what is happening in their lives,” explains Burtenshaw.

When the COAST team arrives on the scene, they conduct a routine mental health assessment of the person in crisis. This involves assessing how the individual appears, their mental status

at the time, socio-economic factors, medical history and past episodes of crisis. They also conduct a risk assessment of the individual to determine whether the person in crisis is at risk of hurting themselves or others, and whether they are able to care for themselves. The COAST team — including the police officers on staff — dress in plain clothes and arrive in a plain car, not a police cruiser. “Not having a cruiser outside their door really helps the families and the clients ... it de-stigmatizes the role of the police being there, and that’s a really big benefit.”

There are certain situations, however, when the COAST team cannot come to the aid of a person in crisis. “We don’t attend barricade calls, negotiations, or any weapon calls,” says Burtenshaw. In rare situations where a weapon is involved, the police have the option of sending a Crisis Intervention Team (CIT) officer to support the person in crisis. A CIT officer is a police officer who has received special mental health training and has successfully completed a 40-hour CIT course. These specially trained officers are easily identifiable by the CIT pins that they wear on their uniform.

Based on the Memphis Model of crisis intervention education for police, the CIT training workshop consists of: information about the causes of mental illness; training in crisis intervention techniques; and education about the *Mental Health Act* and the responsibilities of police officers under the act. One of the textbooks used during this training program is *Not Just Another Call ... Police Response to Persons with Mental Illnesses in Ontario*, which was developed in 2004 through a joint collaboration between the Ontario Police College, St. Joseph’s Health Care London and the Centre for Addiction and Mental Health. The CIT course also provides police officers with information and resources regarding existing community mental health services in their jurisdictions.

A unique aspect of the CIT course is that the officers undertake the training on a completely voluntary basis. “We are always looking for people who want

to actively get involved to make a difference,” says Ontario Provincial Police (OPP) Constable Jay Eberley, the CIT Facilitator for Norfolk County. “We’re asking the officers to volunteer and become involved on their own accord and not because they’re being pressured into doing it.”

In the 100-year history of the OPP, this is the first time, the first location and the first detachment to implement a CIT program. Currently there are 16 CIT officers in Norfolk County, and several officers are also being trained in Brant County. At any given time, for every platoon of 14 OPP officers, there are two to four trained CIT officers. “We have it structured so that there are at least two CIT officers working 24 hours a day,” says Eberley.

Although the OPP have just started to offer CIT training, the training of municipal police officers has been underway since 2004. Thus far, over 250 municipal police officers have been trained in the Hamilton and Niagara Regions and surrounding areas. The CIT and MCIT programs have had a significantly positive effect on the community as evidenced by a 17 percent reduction in the number of people taken to hospital by police and COAST in its first year of implementation. This past year, approximately 20 percent of people assessed by the COAST team were taken to the hospital while the remaining 80 percent were linked to community mental health services and supports, lessening the burden on the hospital ER.

COAST has been recognized for their multidisciplinary approach to providing front-line mental health services, and for their collaborative approach to coordinating community mental health services. On May 27, 2009, COAST was awarded the prestigious National Award for Excellence in Mental Health and Substance Abuse Programming from the Kaiser Foundation.

These crisis intervention programs, however, are not without their own challenges. Under the *Mental Health Act*, the police officer who escorts the

person in crisis to the ER must remain there until the hospital has accepted custody of the person. Due to long ER wait times, this provision under the act is the biggest challenge facing police officers in Ontario. “We’ve seen ER wait times stretch up to 14 hours, 21 hours and even an entire day,” says Eberley. Many of the smaller hospitals in the province do not have in-house security guards, and so police officers are forced to play the role of security guard and remain at the hospital to ensure the safety of the person in crisis and of the hospital staff as well.

Moreover, MCIT programs are not as readily available in rural and northern areas; and thus, the police are often the *only* option for assistance during a mental health crisis in these communities. After officers have escorted the person in crisis to the ER, they must wait until the rural or northern hospital is able to locate a Schedule 1 Psychiatric Facility that has the capacity to admit the person in crisis for in-patient care. Eberley describes this long and tedious process as “bed shopping.”

Even after the ER physician has determined that the person in crisis has to be placed under a Form 1 — which allows a doctor to hold the person in a Schedule 1 facility for up to 72 hours to complete a psychiatric assessment — many hours are spent waiting for a bed to become available. The shortage of psychiatric beds in Ontario has undoubtedly led to increased ER wait times for police officers and for the individuals in need of psychiatric assessment. Currently, the CIT program and the COAST program are working collaboratively with Schedule 1 Facilities and local ER physicians to address wait time issues.

THE PRESENCE OF A mobile crisis intervention team or a CIT-trained officer may have helped Leung in his time of crisis. Unfortunately, he fell through the cracks of the system, like so many others before and after him. In the multidisciplinary team environment of the MSH ACTT, Leung continues to receive comprehensive and culturally sensitive

care, a highly individualized treatment plan, and rehabilitation and support services in both English and Cantonese. Through his work with the MSH ACTT — coupled with his daily regimen of medication that helps to control the symptoms of his illness — Leung is on his road to recovery. He is slowly learning to trust the police once again.

“I can’t imagine what it would be like to have my own family member in the same situation as these individuals,” says Burtenshaw. “Being able to offer a solution, and to let that family know at the end of the day that their child, or their parent, or their partner, is going to be safe, and that everyone surrounding them will be safe ... this is the most rewarding part of my job. Even if it’s just one person’s life that we’ve changed, then it was worth all the work.”

Uppala Chandrasekera is a policy analyst at CMHA Ontario.

fastFACTS

4,727

Number of crisis calls from family members received by COAST’s 24-hour crisis help line in 2008/2009

10,164

Number of crisis calls from clients received by COAST’s 24-hour crisis help line in 2008/2009

1,429

Number of in-person assessments conducted by the COAST mobile crisis intervention teams in 2008/2009

20%

Percentage of those assessed who were taken to hospital

80%

Percentage of those assessed who were diverted away from the ER

How to Respond to Someone in a Mental Health Crisis



Most mentally or emotionally disturbed people have been abused, so most of what you see in people in crisis is FEAR. An aggressive appearance is usually an attempt to keep people away so the person can feel safe. In most cases, anything you can do to reduce the person's fear will help to de-escalate the situation.

Remain calm. Set the tone you want (e.g., courteous, respectful, calm).

Communicate. Ask questions, listen, avoid interrupting, and speak one at a time. Don't argue about what's real, just respond to what you can relate to (e.g., "You're being watched? How are you coping with that? What helps?").

Decrease other distractions.

Ask if you can turn off the TV and radio.
Reduce bright lights and loud noises.

Make a statement about the behaviour you are observing (e.g., "You seem to be afraid, angry, confused"). Ask, "Is this right?" Or, "Please tell me what's making you afraid."

Repeat questions or statements when necessary, preferably short, clear sentences.

Don't assume what the problem is (e.g., not taking medication). For some people, psychiatric medications do more harm than good. Some things you see may be side-effects of psychiatric medications: inability to stop moving, violence, suicidality, tics, twitches, trembling, indifference, etc.

Be an ally to the person in distress with statements like: "I'm here to help. How can I help?"

Avoid judgmental, authoritative statements such as: "You're acting like a child."

Allow the person as much space as you can. Standing over them, getting too close, and blocking the doorway can add to the person's fear and tension (most people with psychiatric histories are abuse survivors).

Don't shout. If the individual appears not to listen, it may be because other voices are louder.

Don't criticize or ridicule (it affects people even if it is not apparent).

Offer choices. Even small choices can help a person retain dignity and reduce fear.

Explain clearly what you are doing and why you are doing it, and if necessary, what you want the person to do and why.

If there is a real physical danger, try to contain the person while you retreat to a safer place.

Source: Adapted from a tip sheet produced by the Empowerment Council, Centre for Addiction and Mental Health, www.camh.net

Invisible Caregiver:

A Father Speaks Out

“Just shut up and pay up” is the kind of angry comment that Ottawa physician Dennis Reid has grown accustomed to hearing from his youngest child Rebecca, 32. Not so long ago, the two had been very close.

Since 2006, Rebecca has gone from a seemingly happy, self-assured professional to a woman living on disability benefits, who has alienated herself from friends and family, seen the revolving door of emergency rooms at most major Toronto hospitals and been put on a cocktail of psychiatric drugs for diagnoses ranging from depression to anxiety, post-traumatic stress, borderline personality and attention deficit/hyperactivity disorder. Rebecca has written suicide notes on the walls of her apartment, woken up other tenants in her building with her loud crying, and repeatedly cut herself. Her first suicide attempt resulted in an involuntary admission to a psychiatric hospital.

Reid says he thinks the break-up of a serious relationship in his daughter's life was the catalyst for the downward slide that ensued. Shortly after the relationship ended, Rebecca met her mother and father for dinner on a family trip in England. "It was probably the worst dinner of my life," Reid says. He listened incredulously to what he describes as "venomous" anger and resentment that Rebecca cast on her family. She accused them of a series of what she now defines as abuses — minor incidents like the time one of her brothers took the TV remote. Throughout a steady string of crises over the last few years, Reid has stuck by his daughter. He has even driven the 4.5 hours from Ottawa to Toronto after she called desperately asking for his help, only to be screamed at and pushed out of her apartment when he arrived.

Reid expresses a frustration and sadness echoed by countless other family members — a term that refers not only to blood relatives, but to close friends who are committed to the well-being of their loved one. When the Standing Senate Committee on Social Affairs, Science and Technology, led by Senator Michael Kirby, was investigating Canada's mental health system, many family members spoke out with their personal stories. As the committee observed in its 2006 report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, families often provide the bulk of support and care to people with mental health problems. Yet, ironically, they're frequently ignored by the mental health and addiction system and excluded from their relative's formal circle of care.

"I was initially told [by one of my daughter's psychiatrists] that the family was the problem, that we should have minimal involvement," explains Reid. "But when she calls me in the middle of the night and wants me to come to her, or to give her money [he gives her about \$20,000 a year], should I be

involved then?" says Reid.

Reid is exasperated by the countless efforts he has made to reach out to his daughter and the professionals in charge of her care. He has written to each hospital where Rebecca has been admitted asking for a proper assessment of her difficulties. In response, he has received polite but dismissive replies essentially telling him it's none of his business. When he and his wife drove all the way to Guelph for a family session at a health centre where his daughter was enrolled in an in-patient program, they were told that they couldn't go in because Rebecca refused to allow them to participate. When he later called two social workers to find out how she was doing, his calls went unanswered. Then suddenly — after five weeks into the program — he got a call saying that she was being discharged from the program because she'd been using profane language and acting out for several days. Once again, she was out on her own, and he was the one there to pick up the pieces.

Reid appreciates that mental health practitioners are legally prevented from revealing any personal information about their client to the family, without the client's consent. But at the very least, he would like to have been informed early on that his daughter had a significant health issue for which she needed help. And he would have welcomed guidance about how best to help his daughter — and himself. For instance, how should he respond when she becomes angry or verbally abusive toward him?

While Reid and his wife benefitted from a family peer support group through NAMI Ontario (the National Alliance on Mental Illness, a non-profit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses), and they did get counselling through an Ottawa psychiatrist who specializes in working with physicians, they were never partners in their daughter's care. In other words, they were never given the opportunity to work collaboratively with the mental health professionals whose care she was under.

While Rebecca has been in crisis, her father has done what many family members do: paid her bills and rent, and tried to navigate a labyrinth of services to find her proper care. According to *Caring Together: Families as Partners in the Mental Health and Addiction System* — a 2006 report initiated by the Ontario-based Family Mental Health Alliance — research indicates that this kind of family involvement helps to reduce rates of hospitalization and relapse, improve their relative's chances of adhering to treatment, and decrease run-ins with the criminal justice system.



"I was initially told [by one of my daughter's psychiatrists] that the family was the problem, that we should have minimal involvement. But when she calls me in the middle of the night and wants me to come to her, or to give her money, should I be involved then?" *Dennis Reid*

family SUPPORT in the ER

by Barbara Neuwelt

Imagine this. You are a family member with a loved one in crisis.

You come to the emergency room (ER) at your local hospital and while your loved one is being seen by a crisis worker you are sent to a family support worker. She helps you understand what is happening to your loved one, offers information and provides guidance to help you navigate the hospital and mental health system. And like you, she's a family member herself, someone who has been where you are. Does this sound like your experience of the ER? It might if you live in Ontario's Grey or Bruce County.

The Family Crisis Support Program is available to family members who come to the hospital emergency department in Owen Sound with a relative or friend in a psychiatric and/or psychosocial crisis. The program is a joint venture of Grey Bruce Health Services (the Schedule 1 hospital for the region) and the Grey Bruce Community Health Corporation (GBCHC), a local agency that provides community-based mental health and addiction services.

Caroline Tykoliz, program director of the mental health team at Grey Bruce Health Services, decided something had to be done to better support the families coming to the ER. Together with Sandy Stockman, executive director of GBCHC, and Judy Kroes, a family member and family support worker at GBCHC, Caroline developed

pilot project that began in 2004 and has been operating ever since.

The goal of the program is to provide support, education and advocacy. The family crisis worker demystifies the *Mental Health Act*, helps families understand privacy laws and explains the routine of an emergency room. She teaches the family what to ask for, what they can expect, and what their rights are. If the family is new to the system, she will go with them to talk to the crisis worker or other ER staff. She tells the family what will happen when the person is hospitalized or why their loved one is not going to be admitted. If the family shares information about a diagnosis, she helps them understand the kind of problem the person has. And she tells them about support programs in the community — family programs for themselves and, if needed, mental health supports for their loved one.

The family crisis worker has no access to the patient health record or any clinical information about the client. Caroline says there's a lot of information you can give without violating privacy laws or the *Mental Health Act*. "A little information, a little support and a little advocacy go a long way."

It's a low-budget program that has a large impact. With one full-time salary and a little bit of money for transportation and office supplies, the family

crisis worker sees 500 people a year, most for one visit, some for two. For further education and support, they are referred to the family member groups available across the two counties.

The family crisis worker works for GBCHC, but is part of the mental health team at the hospital, with an office on the fourth floor where she can bring family members up from the ER. Judy Kroes was the sole family crisis worker operating the program until recently, when the job was split so that there would be backup when Judy is away. Caroline says it took a lot of hard work during the first year to build the relationships that Judy needed within the crisis team and the emergency room. The idea of a non-health professional in the ER was initially viewed as an oddity. It was tough for Judy to crack through that and it required a lot of support from the program director. It was a matter of changing habits and creating new systems. Within a year, referrals from crisis workers were coming fast and furious.

Caroline says that 50 percent of mental health visits to the ER are first-time visitors. Many are parents bringing in young people — teenagers who are depressed, suicidal or experiencing psychosis. Older spouses are bringing in their partners experiencing depression and confusion. Parents and spouses often have been dealing with the problems for a long time until they realize it's out of control. For many families it's their first connection to the mental health system, and when they come to the ER they're met by someone talking their language: no slang, no acronyms.

"I get the biggest rush and my heart fills so much when I read the comments and the quotes from Judy's clients, it's just amazing," says Caroline. "I've worked in mental health my whole life — 32 years — and I think the best thing that I've ever done is to help put this program together."

Barbara Neuwelt is a policy analyst at CMHA Ontario.

by Sandi Kendal

WARM LINES: Preventing Crisis, One Call at a Time



Warm lines — staffed by mental health consumers — are supportive and confidential telephone chat lines used by consumers, their family members, caregivers and friends. Whether callers are feeling lonely or depressed, facing challenges in their recovery, or even experiencing periods of positive change that they wish to share with someone, there is an empathetic voice on the other end of the line who is trained in active listening and there to offer emotional support. Information and referrals to other community programs and services may also be provided.

Warm lines enable callers to resolve issues, talk with others who have been through similar challenges, and protect against the isolation and loneliness that might otherwise escalate into a crisis and ultimately result in a visit to the hospital emergency room.

The first warm line, established in 1994 by Progress Place in Toronto, was followed by the development of similar programs in York Region, Niagara Region and northeastern Ontario, including Sudbury and North Bay. These peer support initiatives have been recognized as a key component of a comprehensive mental health service delivery system — most notably by the Mental Health Implementation Task Forces commissioned by the Ministry of Health and Long-Term Care in 2000 to study services across Ontario and make recommendations for reform.

The Canadian Mental Health Association, Sudbury-Manitoulin Branch, started up its warm line program in 2000 with the support of the Ontario Trillium Foundation, and later used the restructuring of another program to find ongoing financial resources. With the assistance of United Way funds, the program also added weekend hours. Operating seven days a week from 6:00 to 10:00 pm, the warm line provides support during a time when many community mental health services are closed.

The warm line receives an average of 15 to 20 calls per night, with many repeat callers and a higher volume of

“We don’t really give advice ... Whatever their crisis may be, we always try to guide [the callers] to come up with their own answers and make their own decisions. We’re there to support them through the whole process.”

Michael Clark, CMHA Sudbury-Manitoulin Branch

calls during the winter months. While based in Sudbury, this warm line receives calls from across Ontario and as far as New Brunswick and British Columbia. Michael Clark, the warm line coordinator, explains that the Sudbury warm line’s popularity is due to its reputation for providing support. “They say that at the Sudbury warm line, the people listen. There’s more empathy, more of a personal touch, and that we are focused on them, the caller.”

Consumer staff are there to empower callers to make their own decisions about how best to de-escalate their crisis. The goal is to have callers arrive at their own decision as to when and whether to seek help or treatment.

“We don’t really give advice ... Whatever their crisis may be, we always try to guide [the callers] to come up with their own answers and make their own decisions. We’re there to support them through the whole process. When I finish my call, I’m always asking them to call me back tomorrow and let us know how things are going — the follow-up is really important.”

The success of Sudbury’s warm line is rooted in the peer support model. “I think the most important thing about a warm line is that it’s run by consumers,” Clark explains. “The callers know that the person on the phone can empathize, and this may make them more willing to talk about what’s going on.”

Sandi Kendal is a health systems analyst at CMHA Ontario.

SEEI Crisis Studies

Between 2004 and 2008, Ontario's Ministry of Health and Long-Term Care (MOHLTC) invested \$167 million in the province's community mental health system. Funding came from two provincial initiatives: the Federal Health Accord for Home Care and the Service Enhancement Initiative. More than one-quarter of this total investment — \$43 million dollars — was directed towards crisis programs.



In early 2005, the MOHLTC approached the Health Systems Research and Consulting Unit at the Centre for Addiction and Mental Health (CAMH) and requested that it coordinate an evaluation to monitor the investments being made by the government of Ontario in the community mental health system. In response, the Systems Enhancement Evaluation Initiative (SEEI) was developed — a multi-faceted four-year evaluation project. SEEI was a broad collaboration between five partner organizations, researchers, consumer/survivors, family members, service providers, and stakeholders from organizations across the province.

Four of the nine SEEI studies — two system-wide and two program-level — focused on crisis programs in Ontario. Findings from three of the four studies have been released. Innovative aspects of these findings — that have potential to be adapted and incorporated by other systems and programs — are highlighted below for each of the four SEEI crisis studies.



DR. JANET DURBIN,
CENTRE FOR
ADDICTION AND
MENTAL HEALTH

The Impact Study: Province-Wide Survey of Crisis Programs

Dr. Janet Durbin and Dr. Betty Lin from CAMH and the University of Toronto — principal investigators for the province-wide Impact Study — surveyed the province's crisis programs. The team identified 137 organizations in Ontario that provide crisis services and classified these services into five main types: telephone, walk-in, mobile, safe beds, and hospital-based crisis services. A total of 82 percent (113) of these organizations took part in the survey. Participants' responses to two key access-to-services issues — hours of operation and linkages to community supports — are shared below.

Most crisis programs provide day and evening coverage during the week and on weekends. "But unfortunately, the results show that you're better off not having a crisis at night," remarks Dr. Durbin. Only 60 percent of emergency rooms, 40 percent of mobile services, and 25 percent of walk-ins provide service at this time.

The survey asked community crisis programs whether they had formal agreements to accept referrals from police and emergency departments. The goal is to help people avoid more invasive responses to their crisis such as hospital admission or arrest. The survey also investigated how connected community crisis services are with after-care crisis programs, such as case management. Dr. Durbin comments, "Results are encouraging on how connected crisis

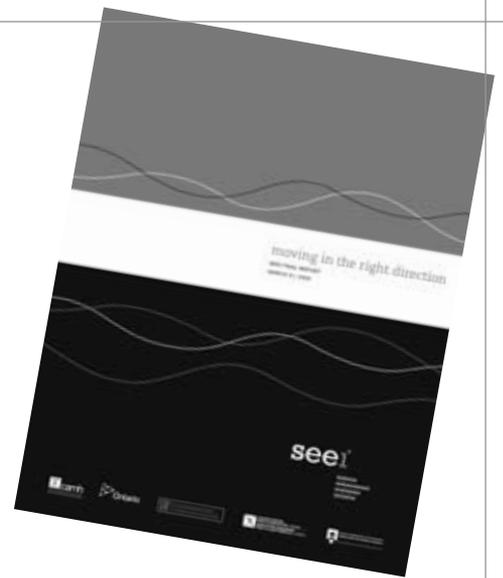
services are with other parts of the system, which help people get the services they need.” This is especially the case for mobile crisis teams which are strongly connected with the police and ER services for incoming referrals, as well as to case management and housing services for after-crisis care.

On the whole, community crisis services are not well connected to primary care — specifically Community Health Centres and Family Health Teams — either to accept referrals or for after-crisis care. Only about 30 percent of walk-ins and fewer mobile and safe bed services had formal connections with primary care. The final Impact Study report will be released in November 2009.

SUMMARY OF PROVINCE-WIDE SURVEY RESULTS: Percentage of community crisis services that have formal agreements in place with other community/ hospital programs and supports.

SERVICE TYPE	FORMAL AGREEMENTS IN PLACE TO ACCEPT REFERRALS		FORMAL AGREEMENTS IN PLACE FOR AFTER-CRISIS CARE			
	POLICE	EMERGENCY ROOM	CASE MGMT.	HOUSING SERVICES	PEER SUPPORT	FHTs/ CHCs/
MOBILE CRISIS	81%	68%	86%	72%	53%	14%/22%
WALK-INS	45%	64%	89%	62%	49%	21%/34%
SAFE BEDS	42%	53%	83%	72%	50%	8%/22%

Survey results reveal: moderate to strong connections between services within the crisis system, and with after-care crisis programs; moderate linkages between the crisis system and peer support programs; weak linkages between the crisis system and primary care.



“Results are encouraging on how connected crisis services are with other parts of the system, which help people get the services they need.”

Dr. Janet Durbin, Centre for Addiction and Mental Health



ELLY HARDER,
CRISIS SYSTEM
COORDINATOR,
WATERLOO
WELLINGTON LHIN

LHIN-Wide Study of the Waterloo Wellington Crisis System

This study evaluated how the crisis system functioned as a whole across the Waterloo Wellington Local Health Integration Network (LHIN), and the *quality of services* that clients received across the system as new funds were allocated. Elly Harder, the crisis system coordinator for the Waterloo Wellington LHIN, and Dr. Joan Nandlal, with CAMH and the University of Toronto, were the study’s principal investigators.

Results revealed that system coordination activities are aligned with best practices. The Waterloo-Wellington-Dufferin Regional Crisis Committee — composed of representatives from police services, hospitals, community crisis services and a self-help alliance — has adopted a core vision and set of principles which includes a recovery orientation. An example of this recovery orientation is a system-wide move towards using individualized crisis plans. Findings show that these plans have yet to be consistently used across the entire system; however, consumer/survivors who are using this tool have the opportunity to plan “how and from whom” they would like to receive supports in the event of another crisis.

Some of the additional funds were used to create a new position for a full-time crisis system coordinator — a dedicated person responsible for establishing inter-agency linkages — to support the development of a highly functioning crisis system. “Oftentimes, program managers try to find the time to do collective

work,” observes Harder. “By valuing coordination work through a full-time position, it provides continuity to coordination across agencies.”

The evaluation also studied the system’s service resolution mechanism which addresses situations where mental health services are not able to adequately respond to a client’s needs. Harder comments, “The service resolution mechanism is a real identifier of strengths and gaps in the system.” Situations that require a lower intensity intervention are often resolved through use of an emergency flex fund — used mainly to cover short-term housing, food or transportation costs which help to resolve a client’s crisis.

Even though the formal evaluation has ended, reports Harder, “We are continuing to use the study’s evaluation framework to move the system forward.”



DR. CHERYL FORCHUK,
UNIVERSITY OF
WESTERN ONTARIO

One Size Does Not Fit All: Urban and Rural Differences

A comparative evaluation of three distinct models of crisis services was conducted in rural and urban southwestern Ontario — each having a differently structured relationship with police services.

On differences between rural and urban areas, the study's principal investigator, Dr. Cheryl Forchuk at the University of Western Ontario, comments, "It's not a one size fits all. The best program model has to take into account the community and the local context."

Results show that transportation was a challenge for people experiencing a crisis, especially for those living in rural areas. The study found that lack of transportation could lead to situations where individuals were forced to travel in unsafe ways to access services. Since rural locations cover wide geographic areas but are low in population density, these communities do not have the critical mass necessary to implement urban-based crisis models. The study recommends that crisis programs serving rural communities adapt a model that integrates a well-seasoned mental health worker — someone with generalist skills — with police service teams that have the ability to travel in rural areas.

In urban areas, Dr. Forchuk points to study findings which indicate that it's preferable for police to be affiliated with a team of specialized mental health workers.

"It's not a one size fits all. The best program model has to take into account the community and the local context."

Dr. Cheryl Forchuk

Consumer/survivors from each of the three communities were concerned about the limited ability of crisis lines to respond immediately to all calls. "We heard over and over again how difficult it was for people to be in crisis and get a busy signal or have to leave a message," comments Dr. Forchuk. "Because it's difficult to staff for crises which are unpredictable, we suggested the establishment of regional back-up phone systems managed across different crisis services to help ensure that callers receive timely support."



DR. TERRY KRUPA,
QUEEN'S UNIVERSITY

Evaluation of an Integrated Crisis-Case Management Service

Results of this program-level evaluation conducted in Kingston revealed that integrating a crisis mobile outreach team with a transitional case management (TCM) service expanded the ability to reach clients, and clients were more likely to be served within a length of time seen as more appropriate for a crisis service. Dr. Terry Krupa, the study's principal investigator from Queen's University, observed, "In trying to address identified service gaps, Frontenac Community Mental Health Services ended up creating a model which qualitatively changed the nature of their crisis delivery."

Incorporation of a new TCM service not only helped to reduce the length of time that clients used the crisis service, but was also able to serve people being discharged from in-patient hospital units. In the old model, more than half of the clients used the crisis service for more than three months. The new model typically served clients within three weeks. Dr. Krupa points out that the TCM "focuses on transitioning people towards autonomy and empowerment and well-being in the community by supporting them to identify and use their strengths and resources."

A second important feature of this new crisis model is the integration of a mobile outreach team. Dr. Krupa comments, "It's the crisis mobile team's focus on community outreach that is preventative." With enhanced capacity, the crisis mobile outreach team was able to make more visits to shelters, food banks, local businesses, and police services. Not only did this help people in the community understand the resources available in the event of a crisis, but the mobile outreach team also learned about what was happening in the community and of situations that potentially required support.

NOW THAT THE STUDIES have finished, the SEEI crisis study reports are being widely disseminated to users of research. More than 450 diverse stakeholders have participated in events around the province to discuss ways in which findings can be applied, and results have been presented to the Ontario Legislature's Select Committee on Mental Health and Addictions and to the Mental Health Commission of Canada.

Information on these and other findings can be found in the SEEI final report, *Moving in the Right Direction*, and in each of the full study reports, posted online at www.ehealthontario.ca under the Mental Health and Addictions portal.

Nandini Saxena is a communications associate at the Centre for Addiction and Mental Health.



Responding as a System to Mental Health Crisis

WHILE EMERGENCY ROOM (ER) visits by people with mental health conditions are oftentimes assumed to be disproportionately high and a significant contributor to wait times, this is in fact not the case. During 2006/07, mental health conditions, broadly defined, represented only 3.6 percent of all ER visits in Ontario. Nonetheless, this represents 189,283 visits during that reporting period, and a percentage of those visits could likely have been avoided.

Emergency rooms are an appropriate point of entry for some people experiencing a psychiatric or medical emergency. Individuals presenting to an emergency room with mental health needs often experience stigma, leading to delays in receiving services and increased wait times. In-service training is required to ensure that people with mental health needs are treated by health care professionals with dignity and respect, and in a timely manner. Reviewing and improving ER triage protocols for individuals presenting with a mental health condition can also reduce wait times.

Strengthening the capacity of hospitals to address people's mental health needs is another strategy to reduce ER visits. The placement of community-based workers in emergency departments has been shown to effectively divert people out of the emergency room and to more appropriate community care. In addition, locating community-based discharge workers in hospital inpatient units can improve access to community services following discharge and decrease readmission rates. The involvement of peer support workers in discharge planning has also been shown to reduce subsequent ER visits.

Lack of access to primary health care and community-based psychiatric care are two other reasons for unnecessary ER visits. In southwestern Ontario, a primary health care program co-located in a community mental health agency resulted in a 50 percent reduction in ER visits for individuals with serious mental illness. Team-based approaches, such as family health

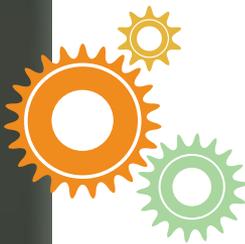
teams, and collaboration between primary health care and community mental health agencies are also effective ways to provide service outside the ER.

Expanding community-based programs for people in crisis is another important strategy for reducing ER wait times. There are a variety of such programs in Ontario, including telephone crisis response, walk-in services, mobile crisis outreach, safe beds and transitional case management, but they are inequitably available across the province. Comprehensive, community-based crisis services are a preferred approach in situations of non-medical crisis. In order to be an effective alternative to ERs, community-based crisis services must be available 24 hours a day and have direct links to both community agencies and hospital backup.

Finally, the ER will often serve as the point of entry for health and social care when alternatives are not available. Expanding the capacity of community mental health services to meet local needs can result in more timely and appropriate care. Increasing the availability of case management, peer support and warm lines (telephone support for persons experiencing distress) have all been shown to effectively support people in their recovery. These services need to be available during evening and weekend hours.

Ontario is on a vital path to improving services and supports for people with mental illness and addictions. CMHA Ontario has prepared several briefs in collaboration with other provincial organizations, offering advice on a comprehensive approach to improving Ontario's response to crisis and reducing ER wait times. There is agreement on the key issues and strategies that can be effective. These reports can be found on our website under "Policy and Research."

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



Working Through It

Stories of **reclaiming well-being** at work, off work and returning to work

An innovative resource for people who are feeling hopeless or overwhelmed with work or life. Featuring practical insights from people who have worked through it to feel better and cope more effectively.

Working Through It offers:

- Practical strategies to assist in coping and surviving through tough times
- An understanding of the struggle and how to overcome it
- Professionals offering their expertise on navigating existing systems
- Printable resources that offer straightforward and practical approaches

Full online version available at

www.gwlcentreformentalhealth.com/wti



www.moodisorders.on.ca



www.mentalhealthworks.ca



Great-West Life
Centre for
Mental Health
in the Workplace

Working Through It was funded through The Great-West Life Assurance Company's national corporate citizenship program in support of the Great-West Life Centre for Mental Health in the Workplace

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 2009 VOL.25 NO.2



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

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