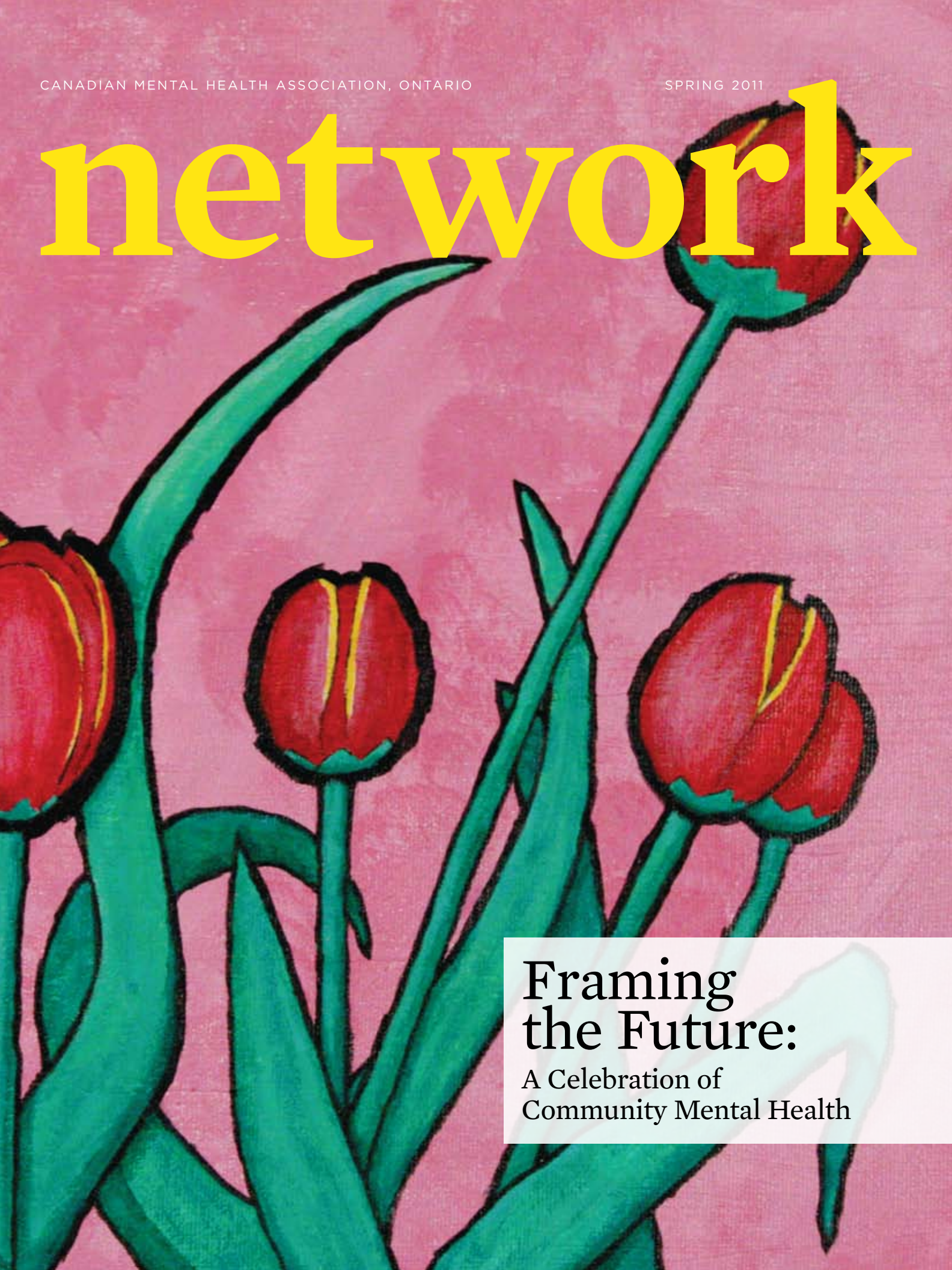
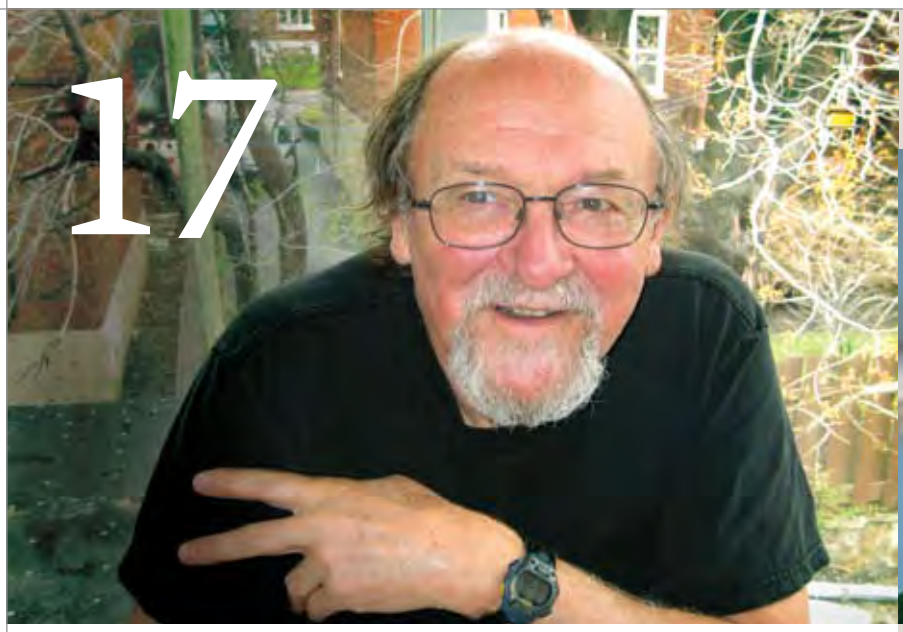
CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO SPRING 2011

network

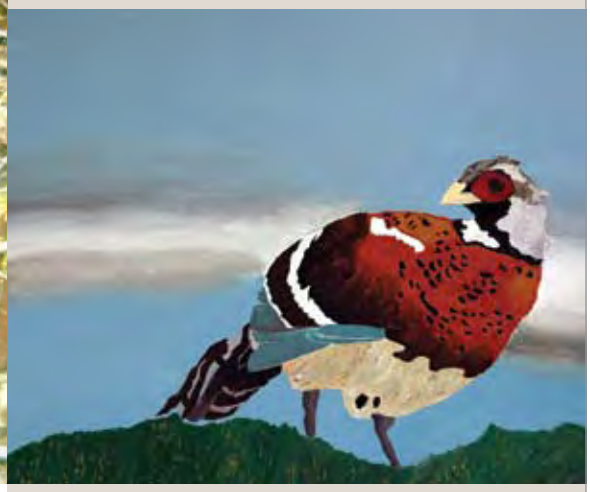


Framing the Future:

A Celebration of Community Mental Health



PAUL BELSHAW, *CHINESE ELLIOT* (ACRYLIC ON CANVAS), 2009.



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Re: Cover

Eileen Koyama, *Untitled* (acrylic on canvas), 2010. This work was produced at Creative Works Studio in Toronto and appears in their 2011 calendar "Reflections on Joy." Creative Works Studio is a St. Michael's Inner City Health program in partnership with the Good Shepherd.

network

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To make mental health possible for all.

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editorial

by **Lorne Zon**

A Fresh Perspective on Community Mental Health

One thing that age has brought me — besides grey hair — is perspective. With 36 years of experience in the health care system, more often than not I am finding that it isn't déjà vu that I am experiencing but rather I really did live it before. As we look back at the evolution of our mental health system, it is often hard to focus on the real changes that have occurred. On the surface it appears that much is the same. Stigma and discrimination are ongoing. Wait times and service access are not what they should be. Funding, well, enough said.

From 1999 to 2007, I was only peripherally involved with the mental health and addiction sectors. When I joined CMHA Ontario and renewed my involvement, I was actually quite amazed at some of the changes that I encountered. Fresh eyes brought fresh perspective. As this edition of *Network* attempts to chronicle some of the changes that have occurred over the past number of years, I wanted to share some of the surprises — pleasant surprises — that I have encountered. The insights are personal. While some may be borne out by research, I make no claim to be evidence-based or to reflect "best practice." However, I believe what I have seen is of great value to us as a guide as we enter the next phase of reforming and transforming the mental health and addictions system.

One insight that comes to my mind is best described as maturity. I don't mean the greyness that my maturity has brought me but rather the notions of wisdom, development, experience and sensibleness. My last foray into mental health and addictions reform was in the 1990s. I remember my key contribution as "shuttle diplomacy." In one room were the addiction service providers, in another the mental health providers and in the third, consumer advocates (consumer/survivors). Bringing everyone together was, to be kind, counterproductive. Today we work together in a natural and collegial manner. To do otherwise would seem unproductive.

A second insight regarding maturity is about mutual respect. As the needs of consumers and their families have taken a more central focus and as recovery has become the central theme for moving forward, the openness of dialogue and the ability to see and listen to each other as we seek common solutions is much different. For me it brings a renewed feeling of hope and potential.

The final comment I will make on maturity relates to our community health service providers. As a health services manager, my days in the hospital sector meant big budgets and large staff. Yes, there were certainly many challenges to be faced to provide coordinated, high-quality care. One of my first responsibilities as the new CEO at CMHA Ontario was do site visits and learn about our branches and their work. I was astounded at the way each branch had built a mini-system for their clients by piecing together funding and programs that were neither designed nor funded to work as a whole. It was a management challenge greater than I had faced. It showed real innovation and determination. If we wish to study value-for-money, we need not look any further.

To paraphrase Robert Frost, "We have miles to go before we sleep," but let's not forget, "We've come a long way, baby!"

Lorne Zon is the chief executive officer of CMHA Ontario.

Building the framework

FOR COMMUNITY MENTAL HEALTH

For almost three decades, *A Framework for Support* has defined community mental health for the Canadian Mental Health Association (CMHA). Well before recovery from mental illness became commonly understood, and even before Health Canada's two-continuum model demonstrated that people with mental illness can still have positive mental health, the Framework raised the possibility that people can transcend their "client" or "patient" status to participate fully in community life.

BY BONNIE PAPE

Original Model

The original *Framework for Support* document was written by John Trainor and Kathryn Church in 1984 to address the tragic fallout from the widespread practice of discharging people from mental hospitals without adequate community supports in place. Moving away from service paradigms and leaning toward the disability movement's values of inclusion, empowerment and citizenship, the Framework presented a simple but groundbreaking model for a community-based system where the person is central, planning is based on individual needs, and natural community processes are tapped to support people's recovery.

In the immediate post-deinstitutionalization era, when "community" was often code for "services delivered outside hospitals," the Framework proposed an entirely different way to think about community mental health. The Community Resource Base, the essence of the Framework model, illustrates the range of resources, besides formal services, that should be available in community. It legitimized the role of peer groups, families, and generic community organizations as bridges to community, and made the case for their input into system planning. It also identified "elements of citizenship" or determinants of health: work, income, housing and education. The Community Resource Base is informed by the Knowledge Resource Base: a variety of knowledge sources: medical, but also experiential, social science, cultural.

Recovery Themes

The Framework policy model was based on a vision that people with mental illness can experience rich community connections and maximum possible control over their destinies. It thus forecast the concept of recovery, even though it did not use that language at first.

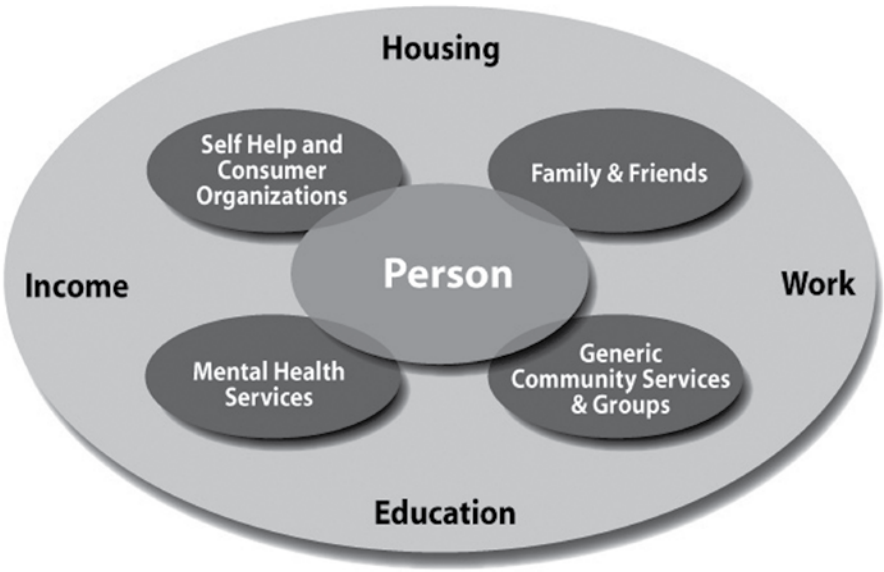
Later on, the recovery link became explicit with a Personal Resource Base describing personal tools that foster a sense of control and recovery: purpose and meaning, inclusion and belonging, positive sense of self, and a practical understanding of our mental health strengths and challenges.

All three resource bases are now seen as pillars of recovery, collectively encompassing the fundamental elements necessary for recovery-oriented community mental health policies. They have universal applications as well; their components can be understood as essentials of mental health for everyone.

A Personal Note

At the time the original Framework model was developed, I was a Masters student with an interest in community health policy and a passion for self-help. Through field placements at CMHA Ontario and CMHA Toronto Branch, I discovered the Framework and joined the CMHA National project team in 1986 on a 45-day contract — which lasted 19 years! Not only was this work a perfect fit for me, but we were situated in the right place. An extraordinary group of Ontario consumers, families, professionals and policy-makers, including skilled and committed project managers, steered the Framework project as it evolved under John Trainor's leadership over the years.

Community Resource Base



SOURCE: CANADIAN MENTAL HEALTH ASSOCIATION, A FRAMEWORK FOR SUPPORT, *THIRD EDITION, 2004*

Practical Applications in CMHAs

Community Resource Base: to bring balance to committees

Knowledge Resource Base: to ensure messages represent a range of perspectives

Personal Resource Base: tool for staff to reflect on their own mental health, and to consider how community resources can positively impact the mental health of the person in the centre

Framework Steering Committee

Long-Term Volunteers
John Trainor *(chairperson)*
Glen Dewar
Bridget Hough
Carl Lakaski
Ed Pomeroy

Long-Term Staff
Bonnie Pape *(Steering Committee staff)*

Julie Flatt *(Consumer Networking Initiative, Routes to Work)*

Wendy Fields *(Routes to Work)*

Linda Huestis *(Seniors' Home Care report; Students' Guide to Higher Education)*

Liz Lines *(Early Psychosis Intervention, Citizens for Mental Health)*

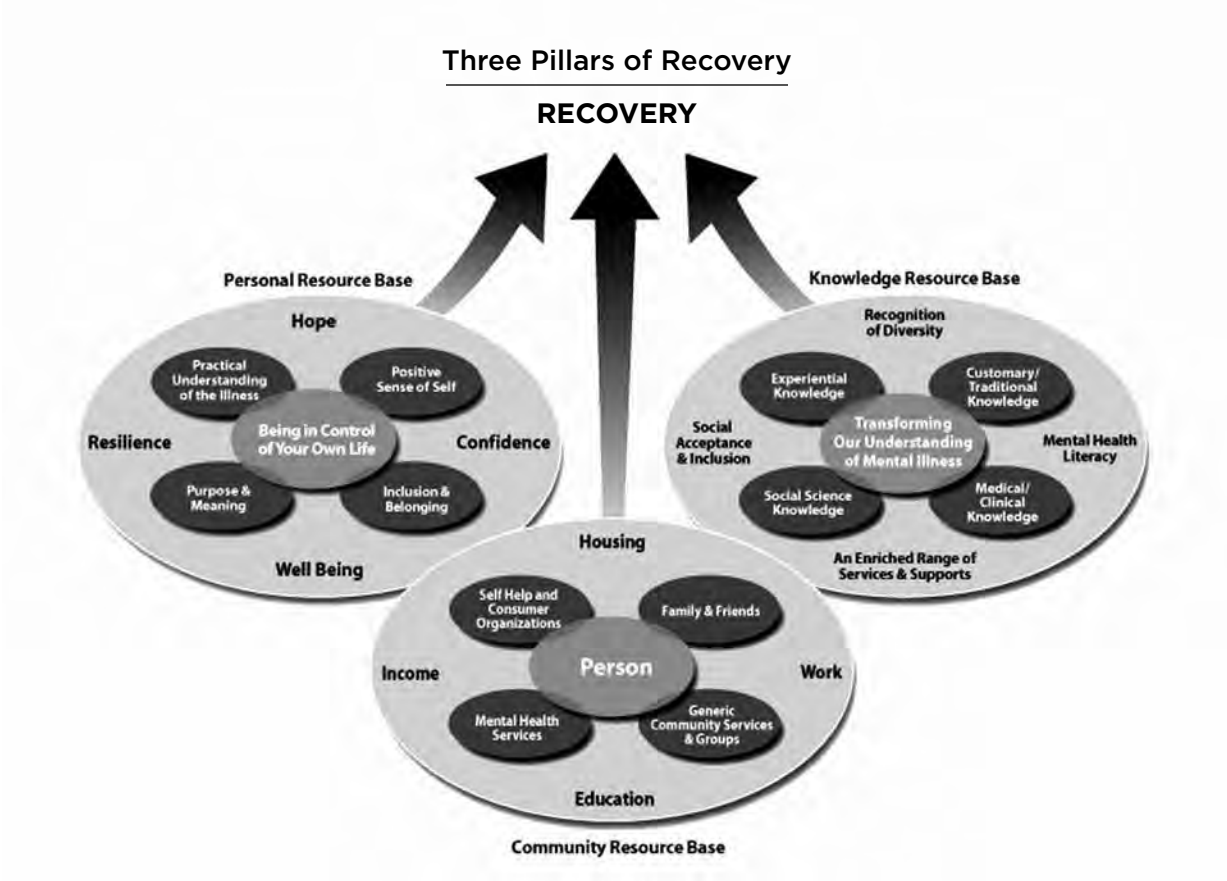
Heather McKee *(Higher Education Best Practices, Inclusion in Community)*

Barbara Neuwelt *(Home Care projects)*

Catherine Willinsky *(Mental Health and High School, Inclusion in Community)*

From Concept to Action: At a Glance

YEAR	ACTIVITY	EXAMPLES OF RESULTS
1985	National conference on Framework vision and moving forward	- volunteer task groups formed - growth of interest across country - policy directions and action plans re: consumer participation in system planning and in community, reinvestment of resources in community, and enabling legislation
1987	Began testing Framework model in communities as a template for structuring mental health planning	- cross-sectoral planning teams in SK, ON, and NB - documented lessons about sensitive process of building partnerships
1988, 1991	Policy forums with federal/provincial/territorial policy-makers	- buy-in and support from provinces - case for government funding of Ontario Peer Development Initiative (still in place today) - New Brunswick Mental Health Commission 1988-98, reflecting Framework model, supported shifts to community system
1989	Began nurturing development of national network of people with lived experience; Julie Flatt met with consumer groups across Canada, inspired them to link with one another	- provincial support for networks - CMHA National Consumer Advisory Council - nucleus of the independent National Network for Mental Health
1990s & 2000s	Support from HRDC and leadership from Ed Pomeroy, Brock University, on identifying accommodations in education and workplace settings	- partnerships with universities and colleges - best practices documents - practical guides for success in education and workplace settings - Routes to Work employment project in CMHA branches (1994-2011)
1990s & 2000s	CMHA branches, regions, divisions in projects with new community partners	- Inclusion in Community project: Ontario CMHAs worked with the YMCA to enhance its accessibility, formed a community theatre troupe, volunteered at local charities - Mental Health and Home Care project: CMHA worked with home care sector to exchange knowledge and test models - Early Psychosis Intervention (supporting young people's recovery and connections to school or work): CMHA engaged mental health professionals, siblings, educators; launched national first-episode families' network



SOURCE: CANADIAN MENTAL HEALTH ASSOCIATION, A FRAMEWORK FOR SUPPORT, *THIRD EDITION, 2004*

The Socio-political Context

The time was right to be exploring these kinds of reforms. Disability rights and psychiatric survivor movements were becoming increasingly visible; people were talking about self-determination and living in community with "a home, a job, a friend." It was fertile ground for Framework concepts to take root and grow.

It also helped to have the federal government on board. Health Canada and Human Resources Development Canada (HRDC), interested in policy directions like ours, partnered with us in a series of policy forums with the provinces and territories. Health Canada's Carl Lakaski became a long-standing member of the Framework steering committee. HRDC, which was working with various national disability groups but missing the voices of those with mental illness, backed CMHA to lay the groundwork for a national organization of people who had experienced the mental health system.

The Framework Today

Over the years, the Framework has been a defining feature of CMHA, and the thread that links us. Steve Lurie's research found that participating in the cross-Canada initiatives contributed strongly to CMHA affiliates' sense of national identity. The Framework's spirit is reflected in what we do and how we do it: community engagement, respect for lived experience, promotion of peer initiatives and inclusion. Its influence extends beyond CMHA as well, in local and provincial policies, and even internationally.

In some ways the world has caught up to the Framework. The recovery literature emphasizes the importance of connecting to the natural community and moving beyond an identity defined by illness; peer support is a component of mental health policies in many jurisdictions; various perspectives now contribute to knowledge exchange processes; and there is a growing knowledge base about accommodating people with mental illness in community settings. We've come a long way since 1984 when shifting the focus to community and including consumer perspectives in policy decisions were radical propositions.

Yet despite what now seems a growing consensus stemming from multiple sources, the *Framework for Support* remains as relevant as ever. After 27 years, it continues to add value to the field with its visionary and balanced blueprint for building a recovery-oriented community-based system.

Bonnie Pape worked exclusively on the Framework for Support project from 1986 to 1990. From 1990 to 2005 she was CMHA National Director of Programs and Research. Bonnie is now an independent consultant in mental health.

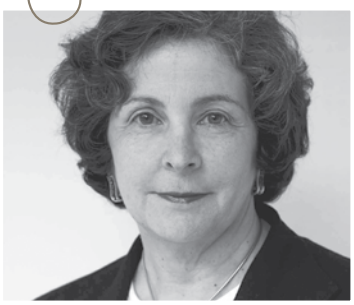


PHOTO BY NANDINI SAXENA

An Interview with Dr. Paula Goering

Dr. Paula Goering, RN, PhD, is an experienced clinician, consultant, educator and researcher. She is a professor in the University of Toronto Department of Psychiatry with cross appointments to the Faculty of Nursing, Institute of Medical Science and Department of Health Policy, Management and Evaluation. She is also an Affiliate Scientist in the Department of Social and Epidemiology Research at the Centre for Addiction and Mental Health (CAMH) and Research Lead for At Home/Chez Soi, the Mental Health Commission of Canada's $110 million, five-city demonstration project on mental illness and homelessness.

The Investigator

by Sheela Subramanian

From 1980 to 2011 she was Section Head of the Health Systems Research and Consulting Unit (HSRCU) at CAMH. Dr. Goering held a ten-year CIHR/CHSRF Chair in Health Services Research that ended in 2010. The Chair, entitled Generating and Disseminating Best Practices in Mental Health and Addictions, created opportunities for interdisciplinary training, mentorship, research and collaboration between researchers and policy-makers. In 2008, she was the recipient of CHSRF's Research Advancement Award in recognition of her national leadership in knowledge creation and translation. In 2010, she was granted an Honorary Doctor of Science degree by Ryerson University.

Q: Three sets of studies — the Provincial Psychiatric Hospital and Community Comprehensive Assessment Projects (CAP), Community Mental Health Evaluation Initiative (CMHEI), and Systems Enhancement Evaluation Initiative (SEEI) — have produced a wealth of information to guide future planning and decision-making. Before these studies, what sources of information were being used to guide planning and decision-making?

There was nothing of this scale before, although there were many smaller studies that may have been used. These three studies were large, and covered multiple programs at multiple sites. All of the studies were funded by the Ministry of Health and Long-Term Care, who was also an active partner in the conduct of the research process.

These studies also marked a way of doing research that was different because they used an integrated knowledge translation approach throughout. What that means essentially is that if you want research to be used to inform decision-making, you need to involve decision-makers throughout the process, especially the people who plan and manage programs, and those who make decisions about policy and funding. All three studies used this approach. They also involved participation from service providers and mental health consumer/survivors. In contrast to research where knowledge translation is done after the research is complete, this was not separate, but always done collaboratively.

Q: What made this collaborative approach work?

Several articles have been written about the approach we took. There were many important ingredients. First, you need to have a government partner that believes in the value of evidence and is willing to participate in the process. We had that in the Ministry of Health and Long-Term Care.

Second, you need a unique group of researchers who work in a collaborative manner. Many of the key researchers involved were at the HRSCU at CAMH and had similar interests and skills. All three studies involved other researchers from across the province, and they too had a similar approach.

Finally, you need partners who are willing to put time and energy into the process. Many organizations and service providers were involved with the data collection and interpretation process.

Q: What was your role in each study?
I was the Project Lead for all three studies, meaning that I conceptualized the overall structure for the research and recruited those involved with implementation. Throughout the time of the studies, I received funding from the Canadian Health Services Research Foundation and the Canadian Institute for Health Research for a Chair in Health Services Research which facilitated my role to lead and operate in a knowledge transfer and exchange linkage model.

Q: This must have been a challenging process at times. What motivated or inspired you along the way?
People were hungry to learn more about what needs were going unmet, and it was clear that the research findings were having a real impact. It was very gratifying to be involved in such a meaningful learning process. Part of the legacy of the studies was also that they provided numerous individuals — consumers, students and others — with opportunities for employment, learning or training. The process also helped to create a culture that was supportive of and positive about evaluation. Organizations that were involved became much less distrustful of or reluctant about evaluation and really saw the value of research for creating new knowledge.

Q: What were some of the important things that we learned about the community mental health sector from the CAP and CMHEI studies?
CAP really focused on met and unmet needs. It started with a look at the provincial psychiatric hospitals, but a look at any part of the system requires you to look at other parts as well. It was an exercise to help government figure out its next steps for the hospital sector. The findings fed into the local and province-wide regional planning tables that were part of the Mental Health Implementation Task Forces.

CMHEI provided some of the best evidence we have about the value of peer support. This was a very important finding.

Q: SEEI produced a wealth of knowledge. What does the community mental health sector need to know about those findings?
I think they would be interested in the overall message that although these new investments clearly created benefits, they were still not enough. There were still needs that were unmet, which meant that further investments are still needed.

Q: From CAP to today, how has the approach to research shifted over time?
We learned that we had to invest resources in knowledge exchange and transfer. With CMHEI, we had a knowledge broker, Dale Butterill, as part of the project, which was key. By the time SEEI was done, we had Heather Bullock and two others doing that work full time and building the Ontario Mental Health and Addictions Knowledge Exchange Network. This was one of our biggest learnings. You need people on both sides of research and decision-making who are interested in working collaboratively, but you also need the glue. Knowledge exchange for mental health must be instituted in an ongoing way in Ontario.

Q: Have the studies been used in decision-making? What is their future legacy?
All of the studies have had an impact. For example, CMHEI played a role in securing the increase in funding that was evaluated through SEEI. The justice sector has been very interested in findings from Carolyn Dewa's Matryoshka Study and Tim Aubry's court support study about positive outcomes and relative unmet needs. The transitional case management study by Terry Krupa has served as a program model that has been taken up by others in the province. Findings from the SEEI ACT study led by Lindsey George have been of interest across Canada. The Impact Study led by Janet Durbin that looked at system-wide impacts and regional variation has been used by many LHINs to describe what is taking place in their region. All of the studies have been used at the local level in different ways.

"People were hungry to learn more about what needs were going unmet, and it was clear that the research findings were having a real impact. It was very gratifying to be involved in such a meaningful learning process."

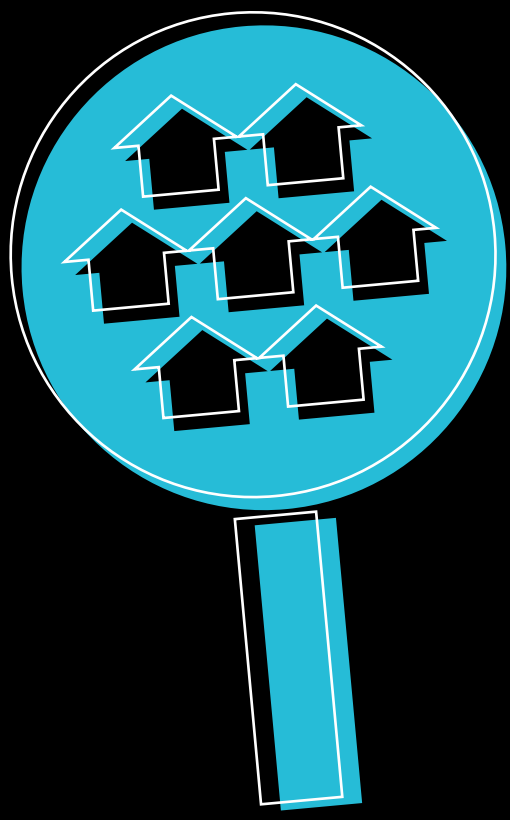
Q: What's next?
The Creating Together initiative had its roots in the goodwill and partnerships created by these studies. It focuses upon the same kind of health services research but includes a broader focus of population health and prevention. The conclusions from Creating Together echo some of the findings of CMHEI and SEEI that showed the need to consider income, education and employment. Creating Together shows that there is still great interest in the social determinants of health and how they come into play when it comes to mental health.

Sheela Subramanian is a planning and policy analyst at CMHA Ontario.

by Sheela Subramanian

Tracing *the* Journey

Building an Evidence Base for Ontario's Community Mental Health System



Mental health reform in Ontario has been marked by a shift from hospital-focused treatment to community-based supports.

This transition has been tracked by major research and evaluation initiatives that have produced invaluable information about our mental health system. The legacy of these studies will inform planning for years to come and includes an enhanced capacity for research and a growing evidence base about the community system's strengths, opportunities and needs.

1998-2002

Provincial Psychiatric Hospital and Community Comprehensive Assessment Projects (CAP)

WHAT? CAP was the first significant study of community mental health services and supports in Ontario, and proved that it was possible to routinely collect data across the system.

WHO? The projects were undertaken by the Health Systems Research and Consulting Unit at the Centre for Addiction and Mental Health, and funded by the Ministry of Health and Long-Term Care (MOHLTC) via the Ontario Mental Health Implementation Task Forces and the provincial psychiatric hospitals.

HOW? 9,360 clinical assessments were collected from over 53,000 adults who received formal mental health services at provincial psychiatric hospitals or outpatient community mental health programs.

The Provincial Psychiatric Hospital and Community Comprehensive Assessment Projects (CAP) were initiated in response to the provincial restructuring of tertiary mental health services. The projects' aim was to develop a system-level picture of mental health consumers with serious mental health conditions. Although the initial CAP studies focused on individuals served by psychiatric hospitals, the project expanded to include a focus on community mental health programs. Initial findings had shown that a significant proportion of adults with serious mental illnesses could be effectively supported in the community, and the research team expanded its focus to ask new questions about whether the community mental health system could meet this demand.

CAP produced extensive knowledge about existing program capacity and the demographics, service use and needs of mental health consumers. A key finding, based on a comparison of recommended and actual levels of client care, showed a high rate of unmet needs across the province based on hospital and community systems providing care at lower-than-needed levels of intensity. In addition, it was found that greater numbers of hospital patients could be served in the community if more services and supports were available, and that there was a lack of system capacity for intensive community support. These service gaps interfered with hospital discharge efforts and put community residents at risk for poor outcomes. At the program level, gaps were identified for concurrent disorder services and broader community supports, especially vocational services.

See "Mental Health Services in Ontario: How Well Is the Province Meeting the Needs of Persons with Serious Mental Illness? Analysis of Data Collected during the Provincial Psychiatric Hospital and Community Comprehensive Assessment Projects (CAP)," 2004.

1998-2004

Community Mental Health Evaluation Initiative (CMHEI)

WHAT? CMHEI was the first multisite evaluation of community mental health programs in Canada.

WHO? The six-year initiative was a collaboration of the Ontario Mental Health Foundation (OMHF), CAMH, and CMHA Ontario, with funding from the MOHLTC. The Health Systems Research and Consulting Unit acted as the coordinating centre for the initiative.

HOW? The initiative included six core research studies that evaluated a range of community-based services and supports; a comparative multisite study; and a project that looked at the usefulness of data collection tools for various community support models, practices and settings.

The goal of the Community Mental Health Evaluation Initiative (CMHEI) was to assess the effectiveness of community-based mental health services and supports in Ontario and build an evidence base for future decision-making about programs and services. Over the course of this initiative, a range of mental health services and peer-support organizations were evaluated in order to identify program activity, monitor progress, and evaluate cost-effectiveness.

The CMHEI studies identified that government investments in community-based services and supports had positive results that made a difference in people's lives. It was also found that community mental health services and supports were saving money. Researchers concluded that it could cost up to five times less to provide an individual with community-based services, than to keep them in hospital for the same length of time. Additional information was gained about the experiences of mental health consumer/survivors, including details of the types of marginalization individuals were experiencing.

Program-level findings indicated that individuals who received peer support had fewer symptoms and hospitalizations than those who did not, that intensive case management (ICM) and Assertive Community Treatment (ACT) programs decreased reliance on institutional care, and that people needed housing, employment, income and health care supports in addition to mental health supports.

The findings from the CMHEI identified the need to provide a range or continuum of programs and services to meet individual needs, including the value of providing peer support as an integral component of a core basket of services. Like CAP, CMHEI increased Ontario's capacity for community mental health research by developing a network of researchers, scientists and community partners.

See "Making a Difference: Ontario's Community Mental Health Evaluation Initiative," October 2004, www.ontario.cmha.ca/cmhei/making_difference.asp.

2005-2009

Systems Enhancement Evaluation Initiative (SEEI)

WHAT? SEEI was a multi-year initiative designed to evaluate the impacts of $167 million in new government investments in Ontario's community mental health sector.

WHO? The initiative was led by CAMH's Health Systems Research and Consulting Unit and an executive advisory committee involving the MOHLTC, OMHF, consumer and family groups, hospital representatives, as well as provincial organizations CMHA Ontario, CAMH and the Ontario Federation of Community Mental Health and Addiction Programs.

HOW? SEEI consisted of nine research studies in two phases. Two Phase 1 studies, Impact and Matryoshka, were longer and began earlier, and seven Phase 2 studies were selected through a call for proposals. The Ontario Mental Health and Addictions Knowledge Exchange Network (OMHAKEN) was also created to develop and share research findings to enhance the system.

Due in part to CMHEI findings, MOHLTC increased funding for certain areas of the community mental health system starting in 2004. Two sources provided the funds: the Federal Health Accord for Home Care contributed $117 million over four years for intensive case management, Assertive Community Treatment (ACT), crisis intervention and early intervention services, while the Service Enhancement Initiative added $50 million over 2005 and 2006 for court support programs, intensive case management, crisis interventions, supportive housing and safe beds.

The two SEEI study phases evaluated the effects of the investments at different levels and services in the community mental health sector. While the Impact Study used administrative data to evaluate the effects of the new investments at the provincial system level, the Matryoshka Study used primary data collection to evaluate early intervention and court support programs at seven locations. The seven Phase 2 studies included an evaluation of a regional crisis system in Waterloo-Wellington; court outreach (or pre-trial diversion) programs in Ottawa; an integrated crisis-care management system in Kingston; the fidelity of province-wide ACT teams; community-based discharge planning in Sarnia; three local crisis service programs in Haldimand-Norfolk, Chatham-Kent and Hamilton; and a Kingston-based evaluation of whether clients were receiving more appropriate care and using fewer hospital resources with the enhancements.

SEEI demonstrated that the investments were supporting the community mental health system to move in the right direction. At the program level, more people were accessing more appropriate community mental health services, with increased numbers receiving the level of needed care, being served earlier, and receiving better continuity of care and improved outcomes. Additionally, the study found evidence of increased innovation and better program models. However, SEEI also found that additional resources were needed to meet client needs, because expanded services in one part of the system increased case finding, and ultimately identified client needs for other services. The studies also identified ongoing gaps in transportation, housing and vocational supports.

See SEEI final reports at https://www.ehealthontario.ca/portal/server.pt/community/seei_final_reports/2182. See also the special issue of Canadian Journal of Community Mental Health, *29 (Supplement 5), Fall 2010.*

2010-2011

Creating Together: Co-Creating a Mental Health and Addictions Research Agenda for Ontario

WHAT? Creating Together was a collaborative initiative designed to develop a health systems and population health research agenda for Ontario. This agenda will be used to guide research investments and knowledge exchange activity in Ontario for the next three to five years. Creating Together offered stakeholders the opportunity to suggest where investments in research can most improve the mental health and addictions system.

WHO? Creating Together was initiated by OMHAKEN in collaboration with 17 mental health and addictions organizations.

HOW? Over 1,600 people participated in in-person or video-conference consultations and surveys.

The Creating Together consultation process identified six priorities for new research concerning mental health and addictions in Ontario: social determinants of health; risk and resilience; health promotion and prevention; stigma and discrimination; continuity of care; and vulnerable populations. The need for greater involvement of people with lived experienced and family members in the research process and community engaged research was also highlighted.

See "Creating Together: Co-creating a Mental Health and Addictions Research Agenda for Ontario," Spring 2011, at http://knowledgex.camh.net/researchers/projects/creating_together/Pages/default.aspx

Sheela Subramanian is a planning and policy analyst at CMHA Ontario.

platform

by Pam Lahey

"Employment of persons in recovery can transform individuals, and when undertaken in significant numbers can transform systems." *

"Don't send me the crazy worker," one Assertive Community Treatment (ACT) client told his psychiatrist after a session with his peer support worker. Helen White, a peer specialist with a large ACT team in Ottawa, takes the comment in stride. "He thinks he is getting ripped off because I am not a nurse or a social worker," Helen says. "It's like I'm something in-between."

Helen's experience of her role as a peer support worker is not unlike the experience of a young Harry Potter: looking for the express train to Hogwarts School of Witchcraft and Wizardry, he is told to board at Platform 9¾, where he finds himself caught half-way between the ordinary world and the world of wizards, not fully accepted in either and viewed with suspicion by all.

In Ontario, the mental health system has seen much change since the years of deinstitutionalization. Less long-term hospitalization, more supportive housing, the rise of employment supports, the development of consumer/survivor initiatives, and a strengthening of the collective voice of psychiatric survivors in system decision-making are proof of this change.

Another indication of a changing system is that psychiatric survivors are being employed in increasing numbers in community mental health services. Prosumers — a term used to describe people with mental health issues that now work in mental health services — are employed in a variety of roles in the mental health sector, including research, service delivery, consulting, management and policy. One of the predominant roles prosumers get hired for in community mental health are designated positions known as peer specialists. These are positions created solely for consumers. To qualify, applicants must disclose the fact that they live with a mental illness.

Before his move into the mental health workforce, Bill Armstrong was working in the trucking industry, a very different environment. Disclosure in his former workplace was considered neither appropriate nor acceptable. "It just wasn't on the table for discussion," he explains. However, during the course of his recovery, which he describes as an eye-opening experience, Bill discovered his passion for helping others who are also working on their recovery. He started on a journey of self-education. As fortune would have it, he read an ad in the local paper for a peer specialist position at the same agency where he had been a client. He knew he had the required experience. "This is exactly what I have gone through," he said to himself. He applied for the job five and a half years ago and has been working there ever since.

Like Bill, Lieutenant Colonel Stéphane Grenier came to peer support the hard way. After a period of trauma-induced illness owing to his multiple deployments overseas with the Canadian Forces, Stéphane sought help. He credits a significant part of his recovery to getting peer support. Peer support literally saved his life, he effuses. "Wouldn't it be great if we could take the elements of this form of social support and create a recipe that can be shared?"

Grenier's recipe now has a name — the Peer Support Project — and it is funded by the Mental Health Commission of Canada (MHCC). Its five-year goal is to "build standards of practice, develop a certification process and, ultimately, legitimize peer support." While there is a lot of fear and misunderstanding about what peer support is or is not, Grenier claims it is not complicated. The MHCC process simply sets out to identify the ingredients that make the recipe good enough to share with the rest of Canada. It combines the organic nature of social support with a knowledge component, taking a complex idea and presenting it as a simple process that the workforce will embrace.

Jai Mills began working in mental health not as a prosumer, but simply as someone who had skills to bring to the workforce. In fact, she purposely hid her consumer status because her experience at that time taught her that to disclose would mean to be treated badly. A seemingly innocent comment from a co-worker, however, would cause her to confront her own fears about disclosure, and ultimately change her mental health career path. "You know if you don't smarten up, you will be more like the people who use this place than the people who work here," her colleague told her. This comment prompted Jai to examine why she hadn't disclosed earlier and contemplate the benefits that disclosure could bring. While the decision to disclose led to some raised eyebrows, and resulted in some colleagues perceiving her as more fragile and less competent, Jai feels the trade-off was worth it. "I felt I was being more genuine, so it created more freedom for me to do what was right." Besides, she adds, "I love spending time with the people who use the mental health system and witnessing stories of strength... Some are a little bit off the beaten track, and not very conservative, but that resonates with me. I am the same."

Far from making her the resident expert, says Jai, her experience of mental illness and of the mental health system is very individual. The only person she is an expert on, Jai insists, is herself: "My experience only advised me of what it is like to be in the position of receiving services, so I am not an expert on everyone's experience." Helen agrees: "We shouldn't assume we are good role models just because we have had a similar experience."

Greg Kim's philosophy around disclosure is similar to Helen's. Now self-employed as a consultant to the mental health and business sectors, Greg has no need to explain his mental health status. He also enjoys the freedom to make his work life fit his personal circumstances. However, when he was working as an employee for others, he disclosed at every job, regardless of whether it was designated a consumer position or not. "I just couldn't *not* disclose," he explains. "How could I work in mental health and not share how I know what I know? I would have felt like I was holding a lie at work."

Helen was likewise forthcoming with her employers, but an experience early on prompted her to be discreet about how and when she decides to disclose. It is also prudent, Helen insists, to consider the disadvantages to disclosing: "I am not sure [whether disclosing is a good idea] because there is a possibility that you ghettoize yourself and then it might be hard to move forward professionally."

Helen's observation is echoed in the research on persons with lived experience providing services to other consumers. Employment in the mental health workforce can be a double-edged sword at times. Prosumers are valued for the first-hand

experience they bring to their job; at the same time, disclosure of that experience may also mean they are viewed as less competent and less skilled.

Disclosing a mental illness in the workplace may also have unintended consequences. In an attempt to prove that your mental illness is not a liability, you may work too hard, too long, and too intensely in order to avoid being accused of being mentally unwell. Greg experienced trepidation about this when he first went to work for a large, high-profile mental health organization in Toronto as a research analyst. "You are worried others are thinking, 'Is he having a mental health day?' So I would soldier on and work too hard."

Career advancement is often an area of concern for service users who choose to work in mental health. Research shows that an employee with a mental illness may feel compelled to conform to organizational culture in order to advance in their career. Despite these findings, this hasn't been Greg's experience: "My identity is at the forefront of how I do the work and why I do that work. I like that a lot." However, Greg qualifies this assertion by acknowledging that his academic qualifications countered any misconceptions about his ability to do his job and allowed him to advance. "I was worried my disclosure would influence my advancement in the organization. It never did. But I had a lot of advantages buffering me against that."

While researchers have documented the many ways that individual service users can benefit through employment in the mental health workforce, the effect of consumer employment on system-level transformation is not as obvious. Nonetheless, changes at the system level are necessary in order to create a more integrated workplace for employees who have mental illness.

Through personal determination and self-advocacy, Helen has managed to shift not only the parameters of her role but also the culture of her organization. When Helen first started her job some 12 years ago, having peer support workers on ACT teams was still a relatively new and innovative practice. She was forging a path for other peer support workers who would follow over the years. Because Helen was one of the first peer specialists in the Ontario workforce, there were no guidelines for her position when she was hired. Since that time, Helen has advocated for changes to her job responsibilities, workload, and pay equity, so that peer specialists would be regarded as equals on the ACT team. For instance, she was initially required to do everything the other mental health workers did, with the exception of on-call duties. This resulted in a significant pay differential. Helen approached management with a suggestion: "I said I would like to do on-call and get paid the same as everyone else." Helen considers herself "a person with a skill set equal to my coworkers but I have a unique experience that I bring to bear on my work." Today, she works full-time and has her own primary caseload, which isn't the case for every ACT team. In her capacity as peer specialist, she also sees every client connected to the team, does home visits, and helps with a range of daily living tasks.

Stéphane shares a similar determination to change the way peer specialists are viewed: "I do believe that the work we're doing will set the conditions to no longer be marginalized and that it will provide access to paid jobs in the future." In order for this to take place, though, decision-makers need to be convinced that peer support is an evidence-based practice that is worthy of continued funding. Creating a framework will allow peer support to be validated. More importantly, the certification process that is part of this framework will convince decision-makers that peer support is the way forward.

Passion and commitment to change are traits shared by many prosumers. Greg had been through the mental health and social assistance systems and was without any financial or social support when he landed a casual job in a mental health drop-in centre in Montreal. This job cemented his determination to change the system for the better. "I was pissed off with how I was treated and wanted to work in the system to make it more humane and improve the lives of others going through it."

Changing the system can also be accomplished, according to researchers, by moving beyond the hiring of consumers only for designated "slots," such as peer specialist positions, to hiring consumers across the organization. This shift would avoid a two-class system where consumers are the "other" staff members; it would also eliminate the need for affirmative action. Some mental health organizations are taking the lead on messaging for consumer inclusion. For example, the Canadian Mental Health Association and the Centre for Addiction and Mental Health have called for mental health, social service and other public sector systems to become "exemplary employers." This action, however, can only occur if those organizations, and indeed the system, are open to change.

During her 34-year career in the mental health sector, Jai has worked in a variety of organizations, including community mental health agencies, hospitals, consumer/survivor initiatives and the Ministry of Health and Long-Term Care. She currently works for one of Ontario's 14 Local Health Integration Networks, as an integration consultant and as co-lead for mental health and addictions. Jai came to the LHIN because she felt that change was necessary at a systemic level. It also presents her with an intellectually stimulating environment where each co-worker holds improvement of the health care system as a core value. As an integration consultant, Jai has worked on many initiatives that have not been focused on the mental health system, and some that have. The LHIN's current focus on improving the quality of the service recipient's experience has led her to a new level of job satisfaction.

"People at the LHIN have accepted me for who I am, so it has not been necessary for me to disclose anything in particular," Jai explains. "The expectations of my work are the same as they are for everyone else. I have required specific accommodations for my vision issues, and those have been provided in a very inclusive and generous way. If I requested an accommodation for a mental health issue, I doubt that I would be treated any differently." Jai's experience has taught her that our mental health system needs to be one that "values the voice of experi-

ence at all levels." This means equal responsibility and equal accountability, but it also means asking ourselves if we are being inclusive enough. One way of being inclusive is to stop compartmentalizing workers with mental health issues. "I don't want to be defined by some of the worst experiences I have had in life," says Jai. "I want to be defined by my strengths."

To be fully inclusive, employers need to think of lived experience — all else being equal — as a unique insight that can complement an employee's existing skill set, not as the only qualification that someone brings. Greg believes that the current trend of credentialing peer support may have the opposite effect: "They have to professionalize us in order to legitimize our role." This narrowly defined focus on consumer roles in the workforce may hinder other opportunities for advancement. "People want to be peer this and peer that," observes Helen, "but is this a good idea if you want to be the executive director of an organization?"

Stéphane recognizes the ongoing debate between the value of credentialing and the danger of losing the organic essence of what it means to offer peer support by professionalizing it. He believes the answer to this tension lies in creating a process that is at once validating without being overly professionalized. He wants to change our understanding of what he describes as a complex, yet non-complicated form of social support. "You don't need three years of university to offer peer support," he says. Stéphane's vision is for the MHCC framework to be translated into a syllabus and delivered by trained peer specialists in the consumer/survivor community.

What would a more integrated mental health workforce look like?

Evidence suggests that a workplace practice such as accommodation needs to be thought of as a benefit that promotes a mentally healthy workplace for every employee, not just a special allowance given to an identified sub-group of workers.

Full workplace integration for workers living with mental illness would mean acceptance, support, and trust among all employees, peers, and managers — not just a gesture to those who are deemed ill. At minimum, it would mean that disclosure did not have to wait until your probation period was up, for fear of dismissal. It would also mean not having to fear the repercussions of disclosure on your professional advancement.

All else being equal, mental health workers who happen to have a mental illness should be seen as just that. No more, no less.

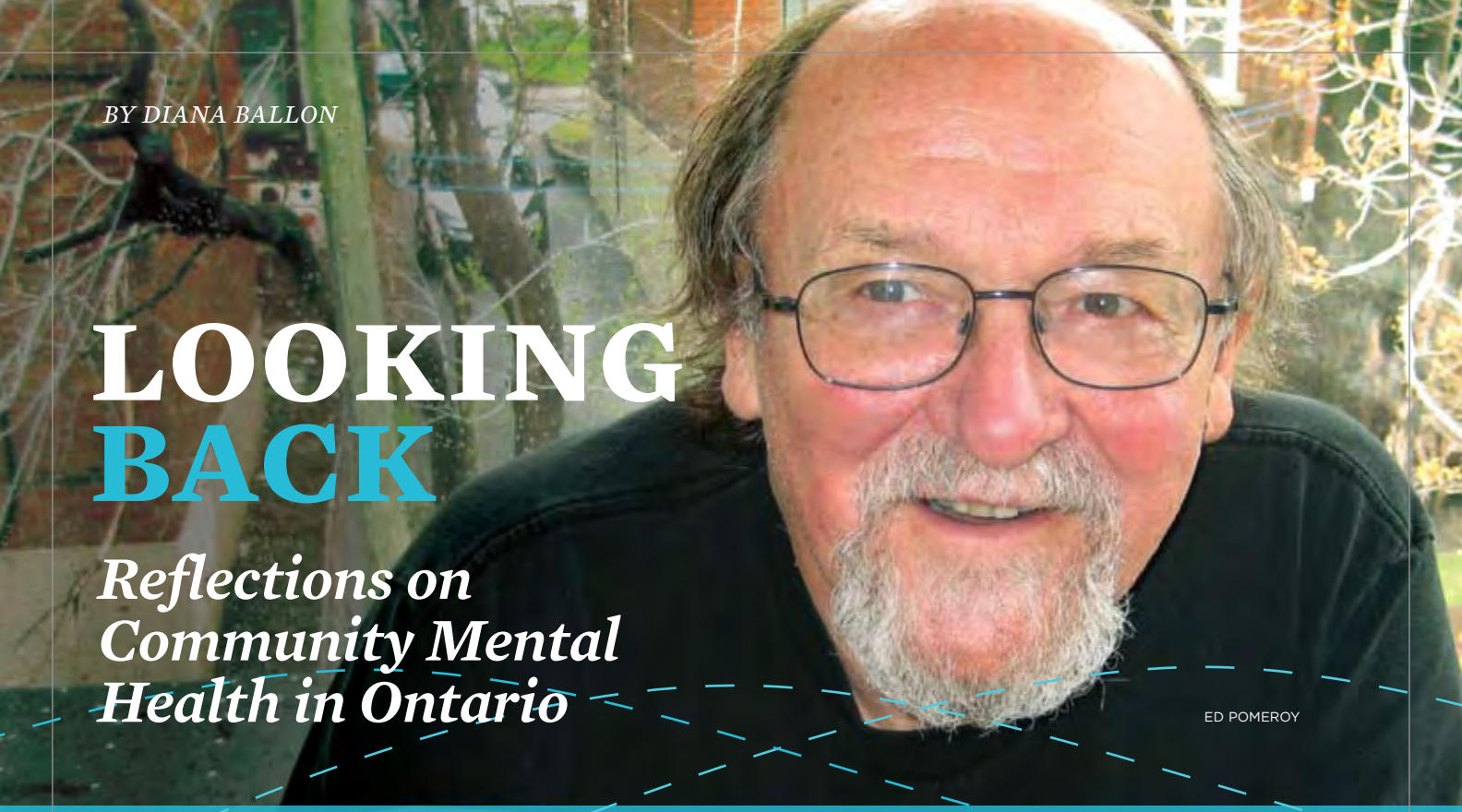
Pam Lahey is a planning and policy analyst at CMHA Ontario.

** J. Wolf et al., "Emerging Practices in Employment of Persons in Recovery in the Mental Health Workforce,"* American Journal of Psychiatric Rehabilitation, *13: 3 (August 2010), 189-207.*

BY DIANA BALLON

LOOKING BACK

Reflections on Community Mental Health in Ontario



ED POMEROY

Sixty years ago, mental health "patients" were being warehoused in asylums, with no voice to express their own thoughts and feelings. No safe space. No belief in any kind of future. Now people with similar mental health problems are integrally involved in managing their own treatment plans, they have access to a greater range of treatment and supports, and a shared sense — with their health-care providers — that recovery is possible.

Stigma persists and discrimination against people with mental health problems continues, particularly for those who are most marginalized and who suffer the most debilitating forms of mental illness. But progress has been made. Looking back over the history of community mental health in Ontario, we have much to celebrate.

The Canadian Mental Health Association (CMHA) was founded as a national organization in 1918 and federally incorporated in 1926. The Ontario Division of CMHA received its provincial charter in 1952. In 1963, CMHA released its landmark policy document, *More for the Mind*, with 57 recommendations concerning mental health care in Canada. *More for the Mind* advocated for deinstitutionalization and the development of appropriate forms of community care. Recommended changes included the need to integrate mental health services within general health services; to decentralize psychiatric services from the provincial government to regional agencies; and to coordinate psychiatric services for patients through all phases of their illness. Every subsequent review of psychiatric services in Canada has reflected these principles.

Deinstitutionalization in the 1950s and 60s led to the closure of almost 80 percent of beds in psychiatric hospitals. However, it took about 20 years to recognize that without the necessary community services in place, deinstitutionalization was a disaster, says Ed Pomeroy, a clinical/community psychologist in the Niagara region and professor emeritus at Brock University. Not only were there not the funds in place to support people with serious mental illness, but mental health providers "maintained a vision that didn't take into account the realities of people with serious mental illness in the community."

In the hospital, people didn't have to worry about food. Even if it was lousy, it was still food. "But out in the community — will people eat?" Pomeroy asks rhetorically. Poor nutrition, access to legal and illegal drugs and abysmal housing moved

people with serious mental illness "from back wards to back alleys," says Pomeroy.

The push to physically move people out of hospital was not accompanied by a corresponding shift in attitude. Pomeroy describes the process in his 1992 article "Citizens Shaping Policy: The Canadian Mental Health Association's Framework for Support Project," co-authored with John Trainer and Bonnie Pape. Mental health providers maintained an often patriarchal, controlling attitude still embedded in a medical approach to caring for the mentally "ill." And consumers and their families were understandably angry, frustrated and hurt. Instead of being respected as experts in their own care, they were viewed as disabled, and seen as without agency or ability to provide input into their own recovery.

Gradually, change began to occur. *Building Community Support for People: A Plan for Mental Health in Ontario* (1988) — known colloquially as The Graham Report — marked the most important shift away from a medical model towards a community-based approach to delivering mental health services in this province, recalls Mike Petrenko, executive director of CMHA London.

The report led to *Putting People First* (1993), the first provincial policy document to outline a 10-year plan for community mental health reform. It committed to prioritizing the needs of people with serious mental illness, and recommended that, by 2003, the Ministry of Health and Long-Term Care commit 60 percent of mental health funding to community services and the remaining 40 percent to hospital care. That split represented the reverse of how funding was allocated at the time.

As District Health Councils and mental health committees emerged, there was a major thrust to invest in community-based services. "For the first time in every community across the province, the providers were all at the same table," Petrenko says. Previously, hospital programs and community programs had been in competition, but now they began to plan collaboratively as partnerships, continues Petrenko. Unfortunately, not much has changed on the financial front: hospitals still receive the majority of funding.

Working with clients — or consumer/survivors, as they called themselves — marked another type of partnership for community mental health agencies, where clients were recognized as experts on their experience, to be consulted with, listened to and respected for their to perspective. The experience of family members was also valued. No longer could doctors be seen as

The Long and Winding Road:

REPORTS, RECOMMENDATIONS AND PLANS FOR MENTAL HEALTH REFORM

Mental health policy in Ontario has moved from an emphasis on institutionalization of people with mental illness to a system that depends on effective and accessible services delivered in the community. This redirection in policy is frequently referred to as mental health reform. Many reports concerning mental health reform have been published in Ontario in the last 30 years. All reports have strongly endorsed the principle of moving mental health care from psychiatric hospitals into the community, where people with mental illness can receive the services they need when they need them.

1983 TOWARDS A BLUEPRINT FOR CHANGE: A Mental Health Policy and Program Perspective (Heseltine Report)
The primary goal of this report was to provide support for the development of a continuum of service delivery, while ensuring that people with mental illness can receive appropriate help in their own communities.

1988 BUILDING COMMUNITY SUPPORT FOR PEOPLE: A Plan for Mental Health in Ontario (Graham Report)
This report followed a series of consultations and recommended that priority should be given to services for people with serious mental illness. The report proposed a plan for the development and implementation of a comprehensive community mental health system.

1993 PUTTING PEOPLE FIRST: The Reform of Mental Health Services in Ontario
This report endorsed the Graham Report (1988) and proposed a 10-year plan for mental health reform in Ontario based on common vision and values.

1994 IMPLEMENTATION PLANNING GUIDELINES FOR MENTAL HEALTH REFORM
This report set out clear expectations for District Health Councils and their role in mental health reform.

the sole "authority" on people's mental illness. And clients could set goals for their own recovery.

The idea of recovery is hardly new, says Vicky Huehn, executive director of Frontenac Community Mental Health Services in Kingston. "Respect, dignity and choice" have been central to the psychosocial rehabilitation movement for over 30 years, Huehn says. Staff members encourage people to talk about their aims and aspirations as part of their recovery journey: the individual with mental illness is the decision-maker, and the staff member is there as a partner.

In the 1980s and 90s, services were gradually developing for and sometimes by consumers: self-help/mutual aid and support groups, consumer-run drop-in centres, clubhouses, 24-hour crisis lines and Assertive Community Treatment (ACT) teams, among other initiatives.

Rather than simply "treating" mental illness, mental health providers also began to recognize the need to consider determinants of health: the fact that income, work, education and housing were also crucial to people's well-being and were conditions that had to be supported.

Housing was the first priority: originally, there were four categories or levels of support in the provincial funding assigned to supported housing. This tiered approach was "absolutely offensive," says Huehn. The fixed levels didn't acknowledge that people's need for support can fluctuate; instead, they implied that people had to "graduate" to move from one level or stage to the next, and that if they went back to hospital they had failed.

Along with a focus on housing was a push toward supported employment. In the late 1980s and early 90s, vocational employment programs were established to enable people with serious mental illness to integrate or reintegrate into a regular workplace. Unlike sheltered workshops that had previously been the norm, these new programs helped people to find "regular jobs": an employment officer would look at a person's skills, aptitudes and abilities (sometimes with vocational testing), help to find the person a job, and then support him or her through the initial adjustments and other difficult periods, as needed. "It's a great support system that continues today," says Petrenko.

Programs continue to become more complex. There's a "maturation of the system," says Huehn. Mental health services established in Ontario have been able to draw on Canadian as well as international research, from such countries as New Zealand, England and Australia, to learn about successful approaches to community care.

1996 DISTRICT HEALTH COUNCIL RECOMMENDATIONS
Based on *Putting People First* (1993), District Health Councils recommended that community mental health services be coordinated through strategies such as joint networks, lead agencies, joint protocols, assessment tools, and tracking with a clear point of access into the system, that models of delivery be based on best practices and that a continuum of services be offered, including case management.

1998 2000 AND BEYOND: Strengthening Ontario's Mental Health System
Based on a consultation led by Dan Newman, MPP, who was Parliamentary Assistant to the Minister of Health and Long-Term Care, this report endorsed the principle of community-focused care set out in *Putting People First* (1993) but noted that at the five-year mark, funding had not yet been allocated to implement needed reform.

1999 BUILDING A COMMUNITY MENTAL HEALTH SYSTEM IN ONTARIO: Report of the Health Services Restructuring Commission
The HSRC recommended that the Ministry of Health and Long-Term Care (MOHLTC) should divest Ontario's nine provincial psychiatric hospitals to the public hospitals. It also recommended transitional funding so that services could be established before the beds were closed.

1999 MAKING IT HAPPEN: Implementation Plan for Mental Health Reform
This report outlines the MOHLTC's strategy "to increase the capacity of the system for comprehensive and integrated treatment, rehabilitative and support services while focusing on community alternatives wherever possible." It was also intended to guide strategic investments over the next three years and committed to protecting mental health funding.

2000 MENTAL HEALTH: The Next Steps: Strengthening Ontario's Mental Health System
This short report on the consultation process on legislative changes to the *Mental Health Act* and the *Health Care Consent Act* states that the proposed legislative changes will "ensure people with serious mental illness get the care and treatment they need in a community-based mental health system."

2000 MAKING IT WORK: Policy Framework for Employment Supports for People with Serious Mental Illness
This report elaborates on the issue of employment supports, providing additional recommendations on issues not adequately addressed in the initial 10-year plan set out in *Putting People First* (1993). The goal was to develop a coordinated response at both the federal and provincial levels to income and employment supports and the business sector.

"We now have the genesis of best practice in terms of services and supports," observes Petrenko. Supported employment has paved the way for consumer-run businesses. People can now get mental health accommodations in both the workplace and post-secondary education. Crisis lines have matured from chat lines to provide mobile capacity with mental health and addiction supports. In the last six or seven years, court support and diversion programs have emerged, to help divert people with serious mental illness in the criminal justice system out of prison cells and psychiatric hospitals into safe bed programs and other types of housing and community support, says Huehn.

Unfortunately, many of our services have reached capacity. "We're stalled," Petrenko says. Pomeroy concurs: there were many ideals post-deinstitutionalization, but today there is "by no means consensus that a lot of progress has been made." The consumer movement has lost momentum, he says. "With the removal of District Health Councils and the huge mandates of the Local Health Integration Networks, we have moved further away from these ideals and more toward professional interests." Even the idea of "recovery" that came out of the consumer movement has now been appropriated by professionals, he says.

The biggest tragedy is "that the consumer voice got lost so easily." It takes work to stay in touch with the needs of the seriously mentally ill, says Pomeroy.

"So where is the optimism?" I ask.

"That we're having this conversation, that we can use words like consumer, survivor, empower, recovery, accommodations… that there are islands of people working really, really hard and really, really well."

Petrenko also sees a positive future for community mental health. "We're on the cusp of transition to a significant emphasis on prevention and mental health promotion," he says, referring to the 10-year strategy for mental health and addictions outlined by the Ministry of Health and Long-Term Care in their 2009 discussion paper "Every Door is the Right Door."

"We've focused on mental illness. We're now shifting our focus to mental health and mental illness," Petrenko says. The strategy is moving towards preventing mental health problems, maintaining positive mental and physical health, and intervening early to treat the onset of mental illness.

People are now talking about mental health problems in a way they never were before.

Diana Ballon is a Toronto writer and editor specializing in mental health issues.

2001 MAKING IT HAPPEN: Operational Framework for the Delivery of Mental Health Services and Supports
This document is a companion to *Making It Happen: Implementation Plan for Mental Health Reform* (1999). It established a framework to reform the mental health system. The report commits to including a continuum of services for persons with mental illness: first line, specialized and intensive. Again, the government re-affirmed its commitment to investment in community mental health care to alleviate pressure resulting from the divestment of psychiatric hospitals.

2002/2003 MENTAL HEALTH IMPLEMENTATION TASK FORCE REPORTS
Nine regional task forces consulted with thousands of people in the field of mental health over a three-year period and submitted nine region-specific reports. A final report of the Provincial Forum of Mental Health Task Force Chairs, *The Time is Now*, identified 11 key themes for reform.

2010 NAVIGATING THE JOURNEY TO WELLNESS: The Comprehensive Mental Health and Addictions Action Plan for Ontarians
The final report of the Select Committee on Mental Health and Addictions, which included representation from all three political parties. Based on extensive consultations, the report makes 23 recommendations, including the creation of an umbrella organization to design, manage and coordinate the mental health and addictions system. The committee also recommended the consolidation of all mental health and addictions programs and services in the MOHLTC, including those for children and youth.

2010 RESPECT, RECOVERY, RESILIENCE: Recommendations for Ontario's Mental Health and Addictions Strategy
The final report of the Minister's Advisory Group (MAG) on Mental Health and Addictions, a group of consumers, family members, health care providers and researchers who were asked to provide the MOHLTC with advice to guide the creation of a 10-year mental health and addictions strategy in Ontario. Five key goals are named: improve mental health and well-being for all Ontarians; stop stigma and discrimination; create healthy, resilient, inclusive communities; identify mental health and addiction problems early and intervene; and provide timely, high quality, integrated, person-directed health and other human services.

LOOKING AHEAD: 2011 AND BEYOND ONTARIO'S 10-YEAR MENTAL HEALTH AND ADDICTION STRATEGY
The Ontario government is developing a new 10-year strategy for mental health and addictions. Two main areas of focus are expected: how to redesign mental health and addiction services to best meet the needs of individuals; and how to create the conditions in communities to help everyone reach optimal mental health and well-being.

MANY HATS

The Evolution of Public EDUCATOR WORK

by Jessica Kwik **PROVIDING PUBLIC EDUCATION HAS BEEN A CORE ACTIVITY OF CANADIAN MENTAL HEALTH ASSOCIATION (CMHA) BRANCHES IN ONTARIO FOR MORE THAN HALF A CENTURY. BUT THE WORK HAS EVOLVED BEYOND SIMPLY PROVIDING INFORMATION TO DEMYSTIFY MENTAL ILLNESS.**

The public educator's activities have spread into areas such as community development and health promotion. CMHA public educators, some of whom began 20 years ago or more, have developed a rich inventory of mental health literacy, stigma reduction and mental health promotion programs. Mental health issues and services are discussed in a broad context that includes everyone, whether one has a diagnosis of mental illness or not.

Margi Clarke is the public educator at CMHA Nipissing Regional Branch, in North Bay. Her job title — Manager of Mental Health Promotion, Information and Education Services — reflects the growing breadth of the public educator role. "No two days are ever the same," she explains. Whether she is responding to questions at a community event, coordinating Mental Health Week activities, collaborating with other organizations to develop support groups, or giving an anti-stigma workshop to students and teachers at a local high school, Margi spends most of her time "out and about in the community."

"I am a real advocate for face-to-face interaction, despite all the other avenues of communication I use. We need to be there when people need the information. It can really make a difference for someone seeking help."

Aleta Armstrong and her Community Awareness team at CMHA Mental Health and Addiction Services of Simcoe County have demonstrated to other sectors the important role that mental health agencies can play within the broader community. Bus drivers, police crisis negotiators, art gallery owners, and health care service providers are among the community leaders who have increased their own mental health awareness by working with Aleta and her team.

At the national level, public education has roots reaching back to the early 1900s, when CMHA founder Clarence Hincks delivered spoken addresses that were covered by local newspapers. In one documented instance in 1920, the *Toronto Star* gave headline coverage to Hincks when he voiced his frustration with the provincial government's lack of concern about conditions in mental hospitals. The incident resulted in *Toronto Star* publisher Joseph Atkinson obtaining an interview for Hincks with the premier of Ontario, who agreed to receive Hincks's groundbreaking report — an early example of how mental health promotion can influence the government's agenda.

Work to improve mental health literacy — defined as awareness of mental health issues and services available, including self-care — can take many forms, depending on the needs and requests in a community. CMHA Toronto, for example, responds to requests for family education workshops and has designed a cross-cultural mental health literacy program, called "Opening Doors," to reach various ethnocultural groups (see "Equity and Diversity: Key Priorities for CMHA Toronto," *Network*, Spring 2010, for more information).

In Barrie, Aleta Armstrong was approached by the local transit authority for "mental health 101" training to help sensitize bus drivers to different mental health conditions. The bus drivers learned what symptoms of depression, obsessive-compulsive disorder, and other mental illnesses may look like. "I realized what a huge support bus drivers are to our clients in the community," recalls Aleta. "The training helped the drivers empathize and relate to the lived experience of riders with mental illness. Drivers could then feel more comfortable in supporting riders." Since the initial workshop, Armstrong has been called back several times to educate new groups and has now trained more than 200 drivers.

Reducing the stigma of mental illness is also an important part of developing mental health awareness and requires extensive reach throughout the community. CMHA Durham Region

JOSÉE DESLAURIERS, MENTAL HEALTH PROMOTER AT CMHA CHAMPLAIN EAST, TEACHING THE TAMI PROGRAM TO HIGH SCHOOL STUDENTS. PHOTO COURTESY OF THE ONTARIO COLLEGE OF TEACHERS.

Branch is one partner on the 21-member Talking About Mental Illness (TAMI) Coalition of Durham, which is supporting youth in anti-stigma work. The community coalition has won two awards for its anti-stigma summits for secondary school students. In the Durham TAMI school presentations, teachers are offered a manual covering a week's worth of material, and the week concludes with a facilitated dialogue with speakers from the community who share their experience living with mental illness. The presentations are also an opportunity to connect youth to services where they are available in schools and community. "Students will attend a TAMI presentation and then they end up running anti-stigma programs themselves," says Christina Papadopoulos, Health Promotion and Public Relations Coordinator at CMHA Durham. (More information about Durham TAMI is available at www.tamidurham.ca.)

For CMHA Mental Health and Addiction Services of Simcoe County, anti-stigma work has also extended into the art community. An exhibit of work by people with lived experience of mental health issues, called "Gifts in Shadow," was developed in partnership with MacLaren Art Gallery. "Now it's a full [three-week] exhibit at the local gallery," explains Armstrong. "It breaks down stigma and it showcases work by those who have never been exhibited in an art gallery."

Mental health promotion is a growing aspect of the public education role. Mental health promotion enhances the capacity of individuals and communities to take control over their lives and improve their mental health, through strategies that foster supportive environments and individual resilience.

The partnerships that are developed by those in mental health promotion roles reveal integrated community responses with broad reach. During the past two years, CMHA Champlain East Branch has worked with the Health Unit of Eastern Ontario to respond to a regional priority revealed through a health status report for eastern Ontario: the area has suicide rates that are almost double the provincial average. As part of the regional strategy, a multi-stakeholder suicide prevention coalition is bringing together people from all five counties. "We need to be proactive and address the gaps that result in these incidences," says Joanne Ledoux-Moshonas, Manager of Mental Health Promotion at CMHA Champlain East. "Many of the suicide cases are people who are not attached to the mental health system. They are not our clients. They see suicide as their only option. These are the people we also really need to reach out to." The coalition has consulted through community symposiums and is now planning an integrated community approach to fill gaps and coordinate existing services for suicide prevention, family support and raising public awareness.

Difficult economic times and stress can

MENTAL HEALTH PROMOTION IN ACTION

INTERLINK
Together There Is Harmony

The Interlink Choir program is a long-standing example of mental health promotion in action. Interlink is a unique inter-generational program that bridges the age gap between children and elders in celebration of words and music. Seniors and children exchange letters and participate in a choir. Interlink is effective in reducing the negative stigma that is often associated with being older in our society.

In North Bay, the program is in its 22nd season. This year it has 40 adult members, ranging in age from young retirees at 55 to "more experienced" members in their late 80s, matched with children in grades 2-6 for pen pal and choir activities. "This is a very active and vibrant group, very committed to the music, sharing their experiences and love of singing with the children," says Margi Clarke, Manager of Mental Health Promotion, Information and Education Services at the Canadian Mental Health Association, Nipissing Regional Branch. The branch offers the Interlink Choir program in partnership with the Near North District School Board. In May 2011, the members continued an annual tradition of preparing a public concert.

Interlink is offered through many CMHA branches across Canada and through other community organizations. The program was launched by Selma Edelstone, who received the Order of Ontario in 1994 and a Queen's Golden Jubliee Medal in 2003 for her efforts.

Learn more about the Interlink program at www.ontario.cmha.ca/interlink.

draw some new audiences to mental health promotion presentations. "When I started, over 10 years ago," says Papadopoulos, "public education involved supporting people with awareness of the facts of mental illness. Now, it's about coping with family, work, managing an illness or self-care as a caregiver, stress and the economy. We let people know you don't need to have a serious mental illness to access services." Workplaces are a common site for mental health promotion, especially during Mental Health Week or times of distress. When an automotive plant was closing in Ajax a few years ago, for example, CMHA Durham was called upon by the union to deliver workshops for staff being laid off, to help people cope with the stress of unemployment.

Public education programs are facing their own financial challenges in today's hard economic climate, just when people need these services the most. Many programs rely on donor funding, which tends to dwindle in poor economic times. Elsewhere, branches have lost public education staff to funding shortfalls. Funding for a youth outreach worker placed in secondary schools in Simcoe County has ended just when schools were beginning to realize the potential of this integrated role. In other branches, the primary mental health promotion position is empty due to loss of funding.

Funding limitations can restrict capacity to reach a range of audiences. The Gerontology Mental Health Promotion Program at CMHA Windsor-Essex County Branch focuses on the geriatric population by taking presentations to apartment buildings, long-term care homes, retiree groups and other older adult programs. But in 2010 the branch lost its local United Way funding for a broader public education program that used to reach high school, college and university students, as well as other members of the community.

In this era of accountability, funders like to put money into programs that show immediate outcomes. Public education, however, is an "upstream" approach and the work is dispersed across many settings and populations, so the effects are not immediately or directly measurable.

Understanding the effects of public education is a key motivator for Christina Papadopoulos. "I moved from case management to mental health promotion and public relations work because I wanted to make more of an impact. I wanted to respond to clients who expressed that the most difficult thing beyond their illness was stigma." Christina can rely on her "virtual public educator team" from other departments at CMHA Durham Branch to support her in her outreach efforts.

The future of this vital role, which reduces stigma and can support earlier identification of mental illness, may depend on public educators promoting the value of the role itself. CMHA Ontario will be knitting together those individuals working at the branches in mental health promotion, community awareness and public education roles to build a stronger network of public educators. The hope is to build a forum to share lessons learned and resources to build capacity. "Together we can be a stronger voice and further public knowledge around mental wellness since we have our individual strengths and programs," observes Armstrong. "We wear so many hats in this role that require such a wide range of skills and knowledge. We can only be stronger as a team."

Jessica Kwik is a knowledge exchange associate at CMHA Ontario.

Community Support for Mental Health Promotion

For seven years, the local Subway franchise of Prescott-Russell has devoted time and resources to an annual golf tournament, a fundraiser to support the mental health promotion efforts of CMHA Champlain East Branch. Gisèle Brunet puts in many hours as the event coordinator, with the support of a local committee, on behalf of her family members who run the franchise. Brunet has garnered a list of repeat donors and begins every January to approach corporate sponsors, people from the community and media. The event has raised a total of $190,000 over the years, and 2010 was a record year with $40,000 raised.

Brunet explains what inspires her family to pursue this mental health promotion cause: "People who attend are close to the cause. We all know people with mental illness. We thought it was important to look at prevention of suicide and other mental health issues and to help young people get some help when it's needed. Schools are a good avenue to reach youth."

Students are introduced to various mental disorders, such as suicidal behaviour, depression, and eating disorders, and they are informed about the causes, warning signs, treatment options and available community resources in Prescott-Russell. As a result of educational sessions with students during the past year alone, CMHA Champlain East was able to identify issues and intervene with 29 students who were either suicidal or had mental health concerns that needed to be addressed.

The results of CMHA's mental health promotion work in schools in Prescott-Russell inspire Brunet and the other organizers to keep up the work. "We get annual reports from CMHA Champlain East and we are pleased with the interventions in the school. Maybe we've saved some lives from suicide through the information that is shared."

The eighth annual golf tournament will take place on Friday, July 8, 2011, at the Nation Golf Course (Curran). For more information, visit www.cmha-east.on.ca.

by Uppala Chandrasekera

THINGS ARE VERY DIFFERENT

OUT HERE

Rural and Northern Community Issues in Mental Health

Geography is a social determinant of health. The health status of a population is inversely related to the remoteness of its location. Consequently, our rural and northern communities face unique challenges — challenges that require customized solutions and a different approach than their urban neighbours.

The 2006 Census indicates that 6 percent of the province's population lives in northern Ontario, an expanse of more than 800,000 square kilometres that accounts for 90 percent of Ontario's land area and has a population density of one person per square kilometre. According to the Ontario Ministry of Northern Development, Mines and Forestry, northern Ontario comprises 145 municipalities, 106 First Nations, over 150 unincorporated communities, and 10 territorial districts, including Kenora, Rainy River, Thunder Bay, Cochrane, Algoma, Sudbury, Timiskaming, Nipissing, Manitoulin, and Parry Sound.

It should be no surprise that a shortage of health care funding and resources are the biggest challenges facing rural and northern communities. Per capita funding, which is the norm throughout the healthcare system, does not take into account the higher cost of providing services to large areas such as northern Ontario, where the population is dispersed across a vast terrain. Moreover, population-based funding typically does not correct for health disparities or for inequitable access to services and supports. Although the two northern Local Health Integration Networks (LHINs) do receive more per capita funding for community mental health than the average in other LHINs, there is still a lack of capacity to adequately meet the population's need for services.

The delivery of mental health services in rural and northern communities differs significantly from urban communities, and multiple factors contribute to this situation. For example, there is a shortage of care providers, especially doctors, in rural and northern communities across the province.

"When I first moved to Elliot Lake, I was fortunate to be connected to a family physician," says Trevor Tymchuk, "but I didn't realize how far in advance I would have to book my appointments." Tymchuk, a resident of Elliot Lake, a small community of about 12,000 people located approximately three hours east of Sault Ste. Marie or two hours west of Sudbury, has to book an appointment six weeks in advance to see his family doctor, even for a simple, routine visit to renew his medication. "My prescription was going to expire before the day of my appointment, so the doctor's office sent me to the emergency room to refill my prescription." Being forced to go to the ER for prescription refills and other non-urgent issues is just one of the issues facing rural and northern Ontarians.

"Life is very different here in northern Ontario," says Anita Webb, executive director of the Kenora branch of the Canadian Mental Health Association. CMHA Kenora, which is located about two hours west of Thunder Bay, provides mental health services and supports to over 700 clients annually who live in the Kenora and Rainy River districts. "There are about 80,000 people living in our catchment area," says Webb, "but there is never an accurate reading because the Census does not include the Aboriginal communities in this region. Often it's difficult to plan for services because we do not have reliable data for the [whole] population."

Similarly, identifying Ontario's rural population is a difficult task because there are different methods for defining what counts as "rural." Due to competing definitions of rural Ontario offered by such organizations as Statistics Canada, the Ministry of Health and Long-Term Care and the Ontario Medical Association, there currently is no standardized definition to help guide policy and research initiatives. As a result, it is very difficult to measure the population health of rural residents, to identify needs and gaps, and to plan and monitor health services.

Through her work at CMHA, Webb has observed a wide range of health issues among rural and northern Ontarians: "Cancer, diabetes and heart disease are so rampant here. In terms of mental illnesses, we see a lot of trauma, mood disorders, personality disorders and a lot of substance abuse and psychosis related to substance abuse. A significant number of people also have fetal alcohol spectrum disorder."

> "There is only one way to get people to understand our unique rural and northern issues. You literally need to drive from North Bay all the way to Thunder Bay, and only then will you understand firsthand how large Ontario really is."
>
> *Trevor Tymchuk, North Shore Community Support Services, Elliot Lake*

These trends are echoed by findings from the Canadian Community Health Survey (2002), which indicates that across Canada, men and women living in rural and small towns have a shorter life expectancy than the average Canadian. These residents also have elevated rates of being overweight, smoking, arthritis/rheumatism and high blood pressure. Furthermore, individuals living in rural and northern areas have higher than average rates of major depressive disorder. Compared to the provincial average, residents of northern Ontario have higher self-reported rates of "fair or poor" mental health, and higher self-reported rates of depression. Medication use is elevated in northern communities, and the hospitalization rate for northern Ontario is twice that of the province.

"Whether people have health problems or not," observes Tymchuk, "there is an issue of isolation here." Tymchuk sits on the board of directors of North Shore Community Support Services, a community-based organization in Elliot Lake that provides psychosocial rehabilitation and support services. He is also an active member of the local and regional Human Services and Justice Coordinating Committees. He describes the feeling as *communal isolation*. "Our community is well aware that we are very far away from everything. For example, we do not have a lot of shopping available here — no bookstores and until recently we didn't even have a shoe store. So you have to drive all the way to Sudbury or the Sault just to do a little shopping."

Migration also contributes to this sense of communal isolation, says Tymchuk. Unemployment and low-income rates are high, and a significant proportion of individuals have less than a secondary school education. Due to the lack of employment opportunities in rural and northern communities, residents often move away to more urban areas in search of work. "There aren't a lot of job opportunities in Elliot Lake," says Tymchuk. "There are some professional positions available, but often the positions go unfilled because it's hard to attract professionals to this isolated community."

"If you are experiencing a mental health crisis at ten or eleven o'clock at night, then the only option you have is to call 9-1-1 and ask the police to take you to the ER. And if you have to be hospitalized, then the police have to drive you all the way to Sudbury."

Trevor Tymchuk, North Shore Community Support Services, Elliot Lake

Workforce recruitment and retention is an ongoing challenge. "We have a shortage of primary care physicians," says Webb. "A lot of the physicians in our community carry more than one role. A primary care physician is also an anesthetist, an OB/GYN, or a specialist in methadone treatment. We may have several doctors, but we don't have enough doctors, especially ER doctors who can work at night." Two years ago, the local hospital in Kenora sent out a notice to the community stating that individuals needing emergency care should not come to the hospital between the hours of 11 p.m. and 7 a.m. because there would be no doctor available. "If there is a tragedy on the highway, then a doctor is called in, but it has to be a dire emergency, and they will evacuate you by helicopter to the closest trauma centre. But between those hours, if you get sick, or you experience a mental health crisis, you have no other option but to wait until the morning."

The basket of services available in these communities is less comprehensive and less accessible than in urban areas. Residents of these regions have limited access to primary health care, medical specialists, hospitals and community mental health services and supports. In Elliot Lake, for example, there is a mental health clinic which provides counselling services, but they do not have a psychiatrist on staff — the only available psychiatrist is one who visits from Sudbury once a month. Moreover, the clinic is only open from 8:30 a.m. to 4:30 p.m., Monday to Friday, and there is no after-hours crisis care.

"If you are experiencing a mental health crisis at ten or eleven o'clock at night," says Tymchuk, "then the only option you have is to call 9-1-1 and ask the police to take you to the ER. And if you have to be hospitalized, then the police have to drive you all the way to Sudbury [to the nearest psychiatric hospital]."

Transportation is another significant barrier to accessing community mental health services for rural and northern Ontarians. Outside of the larger urban centres, many rural and northern communities across the province do not have public transit systems. Without public transit, residents experience the extra burden of high costs associated with arranging private transportation or taxicabs. "The bus system here sucks!" says Anne, a resident of Keewatin, a small town of about 15,000 people located in the Kenora District. "The bus only runs once every two hours, and there is only one bus that goes through the entire town. So I walk everywhere when the weather permits, but it's too cold to do that in the winter."

In Keewatin, the local Assertive Community Treatment (ACT) team has stepped in to help Anne where the public transportation system has failed. "What I like most about the ACT team is, every Wednesday morning when I go grocery shopping, they come and pick me up and take me and my groceries home." Anne has been working with the ACT team in Keewatin for the past eight years, and she says that they are very supportive. "The ACT team is my lifeline, and every week, on our way home from grocery shopping, we always stop for coffee. We talk about serious stuff, and we talk about fun stuff. It's so nice to be with them because they actually make me feel like a human being." Anne is also connected to CMHA Kenora Branch and is very thankful for the mental health services available in her community.

Although there is access to a few mental health services and supports, continuity of care is fragmented in rural and northern communities. Due to the diminished basket of services, individuals living in these isolated areas must often travel to urban areas to access the health services they need. Residents must leave their families and support networks, and absorb the high travel costs. The lack of access to transportation also creates potentially unsafe situations for people using mental health services, such as when individuals are discharged from services in urban communities with no method of returning back home. This is the case for residents of Elliot Lake, says Tymchuk. "Once a person is released from the hospital in Sudbury, they are on their own to get back to Elliot Lake."

For individuals travelling to a scheduled appointment (an appointment with a specialist that was booked through a family physician), the family physician will typically arrange for a Northern Health Travel Grant, a program sponsored by the Ministry of Health and Long-Term Care that provides travel costs for individuals who must travel at least 100 kilometres one-way for a medical specialist or designated health care facility services that are not locally available. "That's fine if you have a car, and can afford to pay the travel costs up front," says Tymchuk. "But if you're a person with a serious mental illness, you don't have a car, and you don't have credit cards, and likely no savings, so you are out of luck. And if you're in crisis, and you're taken to the hospital in Sudbury in the middle of the night, then you're really on your own for getting back home."

Rural and northern communities are working together to find creative solutions to their ongoing challenges. In the

absence of psychiatrists, for example, multidisciplinary primary health care teams are being used to provide services for people with mental health needs. Community-based mental health agencies have developed collaborative care networks, often involving agencies from other sectors, as a means of building capacity and providing support for individuals with serious mental illnesses who have complex needs. Webb says, "In Kenora, we gathered all of the health service providers together, and we got everyone to sign a joint agreement saying that each agency will provide a portion of treatment to complex clients. This agency will take care of primary care, that agency will take care of case management, this organization will provide the housing, etc. In this way, the responsibility is not placed on one agency; rather, everyone collaborates to assist the client in need."

In many rural and northern communities, consumer/survivor initiatives (CSIs) have been successful in providing peer support and enhancing life skills for individuals with mental illnesses and/or addictions. Many CSIs participate on advisory committees at local hospitals and community mental health agencies to inform the planning and delivery of services. Currently, there are 77 peer/self-help initiatives listed in the ConnexOntario database across Ontario, many of which are situated in rural and northern communities. In addition, informal caregivers, including family members and volunteers, are frequently involved where a formal workforce is lacking. However, informal caregivers cannot be a substitute for having access to a professional mental health workforce, and strategies need to be considered to increase the recruitment and retention of mental health workers in rural and northern communities.

In 2009, the Government of Ontario convened a Rural and Northern Health Care Panel to provide recommendations to the Ministry of Health and Long-Term Care about how to better coordinate the delivery of health care services in rural and northern communities in Ontario. A report containing 12 recommendations and a rural and northern framework was released in the winter of 2010; however, mental health and addiction were not addressed in this report as two other initiatives were already underway to address access to mental health and addiction services across the province. In 2010, the Select Committee on Mental Health and Addictions and the Minister's Advisory Group both released their final reports in advance of the 10-year Mental Health and Addictions Strategy for Ontario. Both reports recommended that a comprehensive basket of services be made available to all Ontarians; yet, they did not recommend a specific strategy or framework for mental health in rural and northern Ontario.

Although the province is feeling the pinch of these hard economic times, it is important not to overlook our rural and northern neighbours. Solutions for urban areas cannot simply be transferred to rural and northern Ontario. We need to ensure that all Ontarians living in rural and northern communities have equitable access to community mental health and addiction services and supports.

"There is only one way to get people to understand our unique rural and northern issues," says Tymchuk. "You literally need to drive from North Bay all the way to Thunder Bay, and only then will you understand firsthand how large Ontario really is. And only then will you understand how different life is out here. We need more money and resources simply because of the distance, and simply because everything costs so much more when you live up here."

Uppala Chandrasekera is a planning and policy analyst at CMHA Ontario.

Mental Health and Justice

Based on the Provincial Strategy to Coordinate Human Services and Criminal Justice Systems in Ontario (1997), Human Services and Justice Coordinating Committees (HSJCCs) were established in response to a recognized need in the province to coordinate resources and services, and plan more effectively for people who are in conflict with the law. Priority consideration is for people with a serious mental illness, developmental disability, acquired brain injury, drug and alcohol addiction, and/or fetal alcohol syndrome.

Currently there are 14 regional HSJCCs that coordinate communication and service integration planning among health, social services and criminal justice organizations within specific regions, and 32 Local HSJCCs that provide input to these regional groups. The Provincial HSJCC, consisting of regional chairs and ex-officio representatives from the Ministries of the Attorney General, Community and Social Services, Children and Youth Services, Health and Long-Term Care, and Community Safety and Correctional Services, functions as a provincial planning body.

Over the past decade, the HSJCCs have been advocating for justice/mental health issues throughout the province, within rural and urban areas. They have been instrumental in establishing mental health courts and developing mental health diversion programs to help redirect individuals with mental health conditions who come into contact with the criminal justice system into the health care system. The HSJCCs are also actively engaged in educating the criminal justice sector, including municipal and provincial police officers and correctional officers, about the signs and symptoms of mental health conditions, and how best to respond to individuals experiencing a mental health crisis.

For more information, visit www.hsjcc.on.ca.

BY ZARSANGA POPAL

MANY ROUTES *to wellness*

Integrating Primary Care with Community Mental Health Services

The community mental health sector is integrating primary care into the work it does to help clients achieve good health both physically and mentally.

The approach may vary from organization to organization, but one thing is common: the community mental health sector helps increase access to primary care for people with mental health issues, traditionally a very marginalized population that experiences poor health outcomes.

CONSIDER THE FOLLOWING SCENARIO:

A client meets with her case manager at the local Canadian Mental Health Association (CMHA) branch. She has recently been troubled by a cough, so she is referred by her worker to the CMHA nurse practitioner. During the examination, the nurse asks about the client's family health history and becomes concerned when she learns that the client's father has type 2 diabetes. As a nurse in a mental health setting, she has seen many clients with serious mental illness who have type 2 diabetes. The client says she has never been tested and that she does not have a family doctor. The client agrees to get tested for diabetes after the nurse explains the process and why screening is important. The glucometer test shows that the client has a worrisome blood sugar level. The nurse refers her to a diabetes specialist and, at the same time, the nurse also provides education and support for the client around self-management.

There are a multitude of challenges that people with mental illness experience. In an era of reduced access to primary care providers, people with serious mental illnesses face extra barriers in their attempts to gain access to "the system." Sometimes people get turned away because family doctors may not want to take on clients with complex mental and physical health needs — supporting the care of someone with a mental illness often takes more time than a "regular" visit. Without a family doctor, there are no opportunities for an annual checkup or to monitor chronic health conditions. Care tends to be episodic, occurring through urgent care centres or in already overcrowded emergency departments. Caring for the physical health of people with mental illness is an important issue that needs attention, from both the community mental health and primary care sectors.

Annette Bradfield, a nurse practitioner at CMHA Ottawa, explains that "People with a serious mental illness are not dying 25 years earlier than the general population because of their mental illness. Rather, it is physical health issues that kill people, such as diabetes, heart disease, respiratory disease. For people with a serious mental illness, access to primary care can be a big challenge. It is often part of our work to help people access primary care services, either through what our branch offers or through other providers in the community."

"At our branch," explains Alan Stevenson, chief executive officer of CMHA Lambton-Kent, "we have case managers that advocate for clients to get appropriate primary care. We work with two local community health centres and we have two nurse practitioners from our other programs that we can rely on." Only two of the branch's 700 clients do not currently have access to primary care, continues Stevenson. "We estimate that prior to receiving services from our staff, between 30 and 35 percent of people did not have access."

CMHA Cochrane Timiskaming is starting to integrate primary care into all their programs and services at the branch, not just the clinical programs. For example, the branch nurse practitioner sits in on case management meetings to provide advice on primary care issues and flag any areas of concern. This type of approach moves away from a program-based model to a wrap-around model for clients. By placing the person at the centre and surrounding them with supports, the agency can better address their primary care needs.

CMHA Windsor-Essex County Branch has gone another route by integrating with City Centre Health Care, a satellite program of Windsor Essex Community Health Centre (CHC). Clients can come for mental health and primary care services in the same building. Health care focuses on health promotion, disease prevention and health maintenance.

Those who are rostered with the CHC have full access to primary care, with a multidisciplinary approach. This reduces their need to seek acute care treatment at over-burdened hospital facilities and results in CHC clients having fewer psychiatric admissions to hospitals. Clients also face less stress, knowing that they have direct access to their own primary medical and mental health clinic.

Some family doctors in Ontario will not accept new patients with mental illness because they feel unprepared to meet their mental health needs. To help get around this barrier, case managers and peer support workers in community mental health agencies will go with clients to "meet and greet" a new family doctor, so the physician understands that the person has support for their mental illness from a community agency. This can help reassure the doctor that he or she will not have to deal single-handed

"Serving people with serious mental illness and physical health conditions can be satisfying work. They have complex care needs. It can be a challenge, but it's very rewarding to meet people's needs."

Clark MacFarlane
CMHA Cochrane-Timiskaming

LEFT: CLARK MACFARLANE, EXECUTIVE DIRECTOR, CMHA COCHRANE-TIMISKAMING.
TOP RIGHT: JIM CRICHTON, ANCHOR AT A NEWS IN WINDSOR, CELEBRATES THE GRAND OPENING OF THE CITY CENTRE HEALTH CARE FACILITY. BOTTOM **RIGHT:** PAM HINES, EXECUTIVE DIRECTOR, CMHA WINDSOR-ESSEX COUNTY.

with all of the person's needs, especially the mental health-related ones.

In some cases, clients may not have an Ontario Health Insurance Plan (OHIP) card, and may not have accessed health care for long periods of time because they did not know how to get their OHIP card back. There is sometimes fear associated with applying for identification cards. Community mental health workers can support clients in getting the identification they need to access primary care.

Diagnostic overshadowing is an especially complex challenge for people with serious mental illness. This occurs when the doctor misses a physical health condition because they attribute the symptoms to the person's mental health issue. There are many other factors that may contribute to diagnostic overshadowing, including bias or discriminatory attitudes. The reasons are not always simple, but what is clear is that people with mental health issues are experiencing poor health. Issues related to diagnostic overshadowing can be minimized for some clients with support from a community mental health worker. The worker can help the client articulate their needs and can affirm what the client is saying to the primary care provider. And when primary care is integrated with community mental health services, where the care providers are well-equipped with the skills, knowledge and experience of working with clients with a serious mental illness, diagnostic overshadowing can be significantly reduced.

Another key way that community mental health has integrated primary care into its work is by providing clients with the support they need to get the appropriate tests for their physical health. A pap smear, for example, is an important diagnostic test for women, but as one nurse practitioner explains, it can be a very difficult procedure to undergo for a client who has experienced past sexual trauma. In situations like this, a CMHA nurse or mental health worker may become involved by taking extra steps to help alleviate some of the client's anxiety. They may take her into the examining room before the appointment and familiarize her with the room and equipment. They may also take time to explain the procedure and, if necessary, be with the client in the room during the examination. These steps help many women get through some very difficult procedures.

> "At our branch, we have case managers that advocate for clients to get appropriate primary care. We work with two local community health centres and we have two nurse practitioners from our other programs that we can rely on. We estimate that prior to receiving services from our staff, between 30 and 35 percent of people did not have access to primary care."
>
> *Alan Stevenson, CMHA Lambton-Kent*

Some community mental health agencies provide on-site clinics to screen for metabolic syndrome (MeS) or have partnerships with other providers to help increase access to screening for people with mental illness. MeS consists of a group of risk factors, including obesity, hypertension and unhealthy blood sugar and cholesterol levels, and is associated with cardiovascular disease, stroke and type 2 diabetes. It is clear that people who have a mental illness are at high risk for diabetes and that is why community mental health agencies decided to address the issue. People who have pre-diabetes are now getting connected to preventive care, while those who are diagnosed with diabetes are getting care to help them manage the illness.

Community mental health providers can help clients get back on track with their physical health issues. Assisting clients to get appropriate health education from a primary care provider is part of the process, but the key is helping that client understand the information in a way that is meaningful for them. This often leads to increased self-management and adherence to medical recommendations. Sometimes other health providers can view a person with a serious mental illness as non-compliant because the person is not following medical advice. A community mental health worker will explore the underlying reasons and try to address some of those issues. The traditional medical system does not always understand or address the role of the social determinants of health in a person's life and how they can affect someone's priorities.

A community mental health worker can also play a significant role as a system navigator for a client. The health care and social service system is complex and can be an intimidating place to go looking for help, particularly for those with serious mental illness.

Sometimes a unique approach to health care is needed for people with a serious mental illness. At CMHA Ottawa, for example, a client survey identified that 50 percent wanted to quit smoking. "There is a much higher rate of tobacco use [among people with mental illness] that is not being addressed," observes Bradfield. So the branch decided to meet the need by providing nicotine patches, combined with group counselling, for anyone who wanted to quit. The initiative had positive outcomes and clients who had tried other smoking cessation programs felt that this program worked much better for them. Why did this program work better? Because it was tailored to meet the needs of people with serious mental illness. There are significant complexities that must be considered and addressed in these types of programs. For example, mental health symptoms need to be closely monitored due to the effect of smoking cessation on psychiatric medications.

At CMHA Lambton-Kent, staff members use a health promotion approach, working with primary care providers to raise awareness of the needs of people with mental illness. In Sarnia, for example, the branch has done education sessions with local GPs on psycho-pharmaceutical care. Building this type of relationship between the sectors is a benefit to clients.

Clark MacFarlane, executive director of CMHA Cochrane-Timiskaming, cautions that "there should not be ghettoization of primary care services for people with mental health issues. It is important that people with mental illness have choices in their primary care." He also points out that part of the role of the community mental health sector is to bridge people into other services and that those services need to be able to respond to the needs of people effectively. It is a two-way relationship that needs both sides to do their part.

MacFarlane also raises some important system issues on the integration of community mental health and primary care. "Integration works well between community mental health providers and external primary care providers," he explains, "but consent has to be considered as a key element of this process. It also has to be consent that is in accordance with PHIPA [*Personal Health Information Protection Act*]. And just as important, there needs to be reading and understanding of the information that is going back and forth between providers in a timely and effective manner." MacFarlane believes that in order to do this work effectively, "both provider sides need support and tools to share information in an appropriate and respectful way. There needs to be more policy direction in this area."

Better integration of the primary care and mental health sectors can improve the quality of care that people receive. "This approach also provides cost-savings to the health system," continues MacFarlane. "If physical health issues are dealt with early, then it prevents long-term complications that can cost the health system more money." More importantly, early detection and treatment of physical health conditions can lead to better quality of life for the individual and can improve their health outcomes.

The community mental health sector has demonstrated an important strength by integrating primary care into a continuum of services that can help improve access to primary care for people with mental illness. Ultimately, community mental health agencies are also improving health outcomes for a marginalized population that experiences multiple barriers to care. As MacFarlane puts it, "Serving people with serious mental illness and physical health conditions can be satisfying work. They have complex care needs. It can be a challenge, but it's very rewarding to meet people's needs."

> "People with a serious mental illness are not dying 25 years earlier than the general population because of their mental illness. Rather, it is physical health issues that kill people, such as diabetes, heart disease, respiratory disease."
>
> *Annette Bradfield, CMHA Ottawa*

Zarsanga Popal is a planning and policy analyst at CMHA Ontario.

by **Michelle Gold**

Moving Forward on Mental Health and Addictions

This issue of Network magazine recognizes progress in the evolution of community mental health, in both policy and practice, over the past 30 years. Ontario's strategy to reform the mental health system, "Making It Happen," was released by the Ministry of Health and Long-Term Care in 1999. This strategy was intended to categorize services according to level of need at a time when the government was divesting provincial psychiatric hospitals. While various task forces and recommendations for mental health reform have occurred over the past decade, it appears we are only now close to the release of a new mental health strategy for Ontario — one that will also include addictions.

This will be the first time that Ontario has a combined mental health and addictions strategy. Since 1999, Ontario has had a parallel strategy for addictions, "Setting the Course." As a result, mental health and addictions have had separate bureaucratic structures, funding and service systems. While the development of addiction services has been predicated on both abstinence and harm reduction philosophies, the prevailing approach of the Ministry of Health and Long-Term Care is harm reduction. This perspective shares common ground with the recovery philosophy that underlies community mental health services.

It is estimated that 15 to 20 percent of the Canadian population with problematic substance use have a co-occurring mental illness, but not all will seek treatment. Among individuals seeking treatment for problematic substance use, the estimated rate of concurrent disorders increases to 70 percent. The estimated prevalence of concurrent disorders among people seeking treatment for mental health issues is lower, at 20 percent. Concurrent disorder rates are greatest among young males, women who have experienced trauma and people who are homeless.

While Ontario is developing a combined mental health and addictions strategy at the policy level, collaborative work is already in evidence in communities. A recent survey of Canadian Mental Health Association branches in Ontario indicated that 85 percent are currently providing some level of service for individuals with concurrent disorders (23 of the 27 branches that responded). We assume this trend is also occurring among other community mental health agencies in the province.

The Four-Quadrant Model (see figure 1), developed originally in the United States and put forward by the Concurrent

Disorders Ontario Network in 2005, is a framework used by many agencies to guide how mental health and addiction providers can work together to provide services to individuals with concurrent disorders. Depending on the severity of each co-occurring condition (low–high) located within a two-by-two matrix of possibilities, there are four potential settings for service coordination and integration: primary care, specialized mental health services, specialized addiction services and specialized integrated services. This framework offers guidance on how the mental health and addictions systems can work together to: enhance each other's ability to assess and refer individuals to the most appropriate provider (a no-wrong door approach); collaborate through consultations, service agreements and/or shared care; deliver fully integrated services; and support clients' access to other services such as supported education, income support and housing.

The most common rationale given for integrating mental health and addictions is based on the fact that many people experience both conditions. While the percentage of people with concurrent disorders in the general population is not as high as previously thought, even a relatively small population can experience significant challenges and high resource needs. However, a recent report by the Canadian Executive Council on Addictions (CECA), "On the Integration of Mental Health and Substance Use Services and Systems," suggests that there are likely other factors behind the impetus to integrate mental health and addictions. Many of these factors are not related to concurrent disorders, or are only marginally so. These include perceived administrative efficiencies of bringing two small sectors together and anticipated cost savings in a time of economic pressure.

According to CECA, while integration of mental health and addictions is most compelling in the case of concurrent disorders, caution should be exercised when setting any overall directions for integration of mental health and addictions: adequate attention must be given to what type and level of integration, and for whom.

The Co-Occurring Center for Excellence (COCE), a program of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S., broadens the dialogue by indicating that the majority of people with mental health, addiction and concurrent disorders are also receiving services from the wider health and human services system, including primary care, emergency departments, income support services, housing and the justice sector. Integration with the broader system is therefore likely to be just as important for mental health and addictions. Recently, "tiered models," which include a focus on prevention and

A recent survey of Canadian Mental Health Association branches in Ontario indicated that 85 percent are currently providing some level of service for individuals with concurrent disorders.

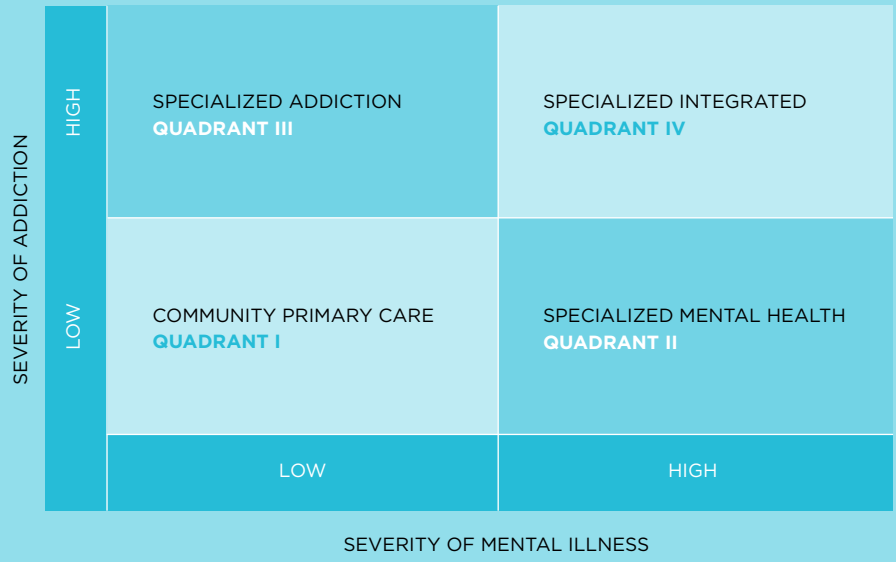
In Quadrant I, primary care settings, supported by consultation with the substance use and mental health systems, are the focus of treatment for those with low-severity substance use and mental health issues.

In Quadrants II and III, the specialized substance use and mental health systems collaborate to serve those for whom one disorder (mental health or substance use) is high-severity while the co-occurring disorder is low-severity (e.g., a severe mental illness together with a less severe substance use problem; or substance dependence plus a less severe mental illness).

Quadrant IV requires the two systems to come together to provide specialized, integrated services for those with severe and co-occurring substance use and mental health disorders.

FIGURE I

The Four-Quadrant Model



SOURCE: CONCURRENT DISORDERS NETWORK ONTARIO, "CONCURRENT DISORDERS POLICY FRAMEWORK," SEPTEMBER 2005

Integration efforts in Ontario should be guided by a provincial framework and general principles reaffirming that the central objective of mental health and addiction integration is to improve client experience and quality of care.

health promotion, have been developed to guide planning of an integrated service delivery system. The Canadian Centre on Substance Abuse has recommended this type of systems approach that responds to the complexity of needs within the population being served.

COCE distinguishes between service-level integration and system-level integration. The former involves services and supports, similar to those defined by the settings and functions of the Four-Quadrant Model described above. But in the case of the broader framework for addressing mental health and addiction, the matrix and the possibilities for integrated services is much greater. Service integration, which addresses service-level collaboration and coordination, can enhance continuity of care and quality of care. System integration can facilitate service integration. However, if system-level integration efforts are not ultimately designed to support services, integration is not likely to have a demonstrable impact on client outcomes.

COCE cautions that there is no evidence that system integration on its own improves client outcomes. They suggest that system integration "should be undertaken with a clear organizational commitment to evaluating outcomes and impacts within a process of continuous quality improvement." As we move forward in this province to implement a comprehensive and broad-based mental health and addictions strategy to meet the needs of Ontarians at risk of, or currently experiencing, a mental illness, an addiction or both, it will be important to put in place enablers that support an integrated mental health and addictions system and appropriate evaluation strategies.

In 2010, six provincial organizations, including CMHA Ontario, presented a discussion paper to the Select Committee on Mental Health and Addictions on how Ontario should address integration. We recommended the development of a provincial framework that would identify how to implement an integrated mental health and addictions system. Such a framework would provide guidance to Ontario's Local Health Integration Network (LHINs) on the key objectives of integration and general principles which should govern integration efforts. These principles should reaffirm that the central objective of mental health and addiction integration is to improve client experience and quality of care.

Given that the processes and mechanisms for enhancing integrated services are predominantly undertaken at the provider level, new integration efforts should draw inspiration from the many excellent initiatives and innovations already occurring in Ontario. Local solutions are best achieved through the engagement of service providers and people with lived experience. LHINs should have the flexibility to support integration that will improve client care, within the parameters of provincial policy and the directions of a provincial framework for an integrated mental health and addictions system.

System-level integration supports also need to be put in place, such as ensuring an adequate work force, with particular attention to remuneration and training; creating program standards; and developing relevant indicators, data collection tools and information technology to support performance monitoring and continuous improvement. While organizational "solutions" based on directions for fewer agencies are often looked upon as the remedy, it is only one possible approach. Just like the Four-Quadrant Model, there are various options for services working together to improve the mental health and addictions system in Ontario. As the government moves forward with the first combined mental health and addictions strategy, we need to ensure the implementation of an integrated services framework, supported by system-level integration enablers, to best meet the needs of Ontarians.

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My fiancé and I play instruments.
Michelle 29, Costumer

I hit the gym when I can.
John 58, Electrician

Look at life positively.
Alicia 40, Caregiver

I meditate.
Brata 54, Musician

I like being creative. It's my drug.
Zile 67, Artist

Chill with my friends.
Brian 23, Student

Spend more time with my husband!
Daisy 30, Administrator

I try to help others. It makes me feel good.
Walter 50, Postal Worker

I read.
Aster 34, Student

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