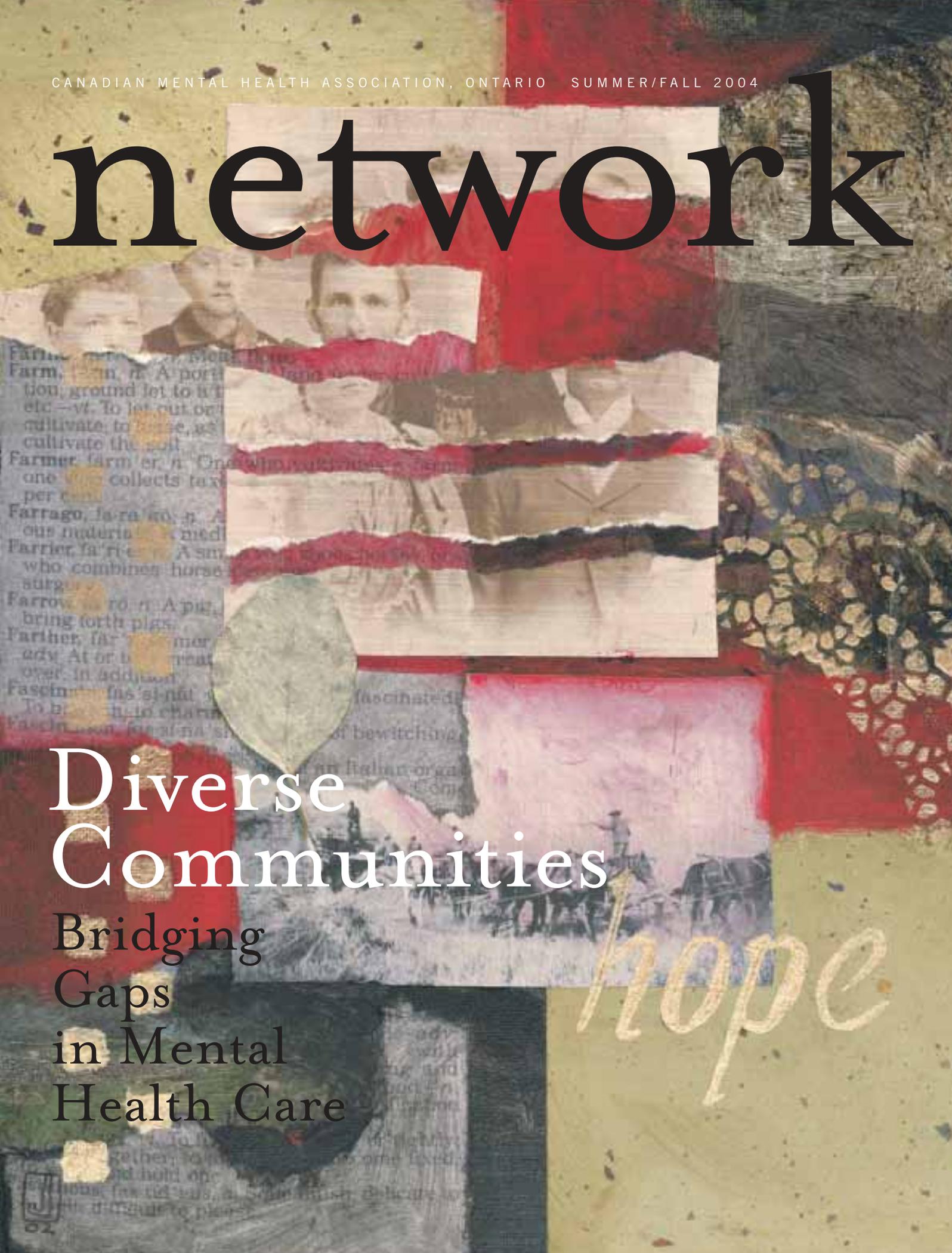


# network

## Diverse Communities

Bridging  
Gaps  
in Mental  
Health Care

rope





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

#### EDITORIAL COMMITTEE

Scott Mitchell, Editor  
Susan Adams  
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#### CHIEF EXECUTIVE OFFICER

Barbara Everett, Ph.D.

#### CONTRIBUTORS

Sarah Evans, Valerie Johnston,  
Heather McKee, Liz Scanlon,  
Mary Alice Smith

#### DESIGN

Soapbox Design Communications Inc.

#### ADMINISTRATIVE ASSISTANT

Susan Macartney

#### PRODUCTION COORDINATOR

Christine Bilusack

#### OUR MISSION

To provide leadership in advocacy and service delivery for people with mental disorders, and to enhance, maintain and promote the mental health of all individuals and communities in Ontario.

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

TELEPHONE 416-977-5580

FAX 416-977-2264

E-MAIL [network@ontario.cmha.ca](mailto:network@ontario.cmha.ca)

WEBSITE [www.ontario.cmha.ca](http://www.ontario.cmha.ca)

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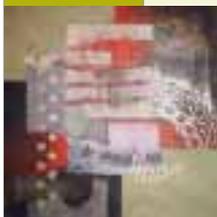
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Jennifer Osborn, *Immigrant Song* (mixed media, 12" x 12"). Reproduced by permission. A consumer and a young woman of considerable artistic talent, Osborn created the original artwork for the Emerging into Light logo, a symbol of courage, resilience and recovery. She is currently studying art at the Sheridan Institute of Technology and Advanced Learning in Oakville, Ontario.

Barbara Everett, PH.D.  
Chief Executive Officer



## Diversity and Health

P

People with mental illness often complain that, once diagnosed, they are labelled. By this they mean that their identity has been overtaken. They feel one-dimensional – a schizophrenic, a depressive, a bipolar – and are often referred to in these terms. But people with mental illness are also employers and employees, mothers and fathers, grandparents, sisters and brothers. They are old, and they are young. They are athletes, artists, musicians, gardeners and many, many other things. They are also Aboriginal, Deaf, living with HIV/AIDS, or from countries other than Canada.

This issue of *Network* looks at people who are, first and foremost, people but who have a multiplicity of identities, only one of which relates to their struggle with mental illness. The issue begins with an interview with the Honourable Dr. Marie Bountrogianni, the Minister of Children and Youth Services and the Minister of Citizenship and Immigration. Dr. Bountrogianni not only has two ministries, she is, herself, a woman of many identities. Her experience as a child of immigrants and as a psychologist specializing in children's issues informs her dual portfolios, but she also points out that she is both a politician and a parent.

First Nations people in Ontario are Miyew, Anishinaabe, Oji-Cree, Haudenosaunee, Métis and Inuit. But they are also people struggling to heal from the mental health problems caused by removal from their parents and communities to a life of abuse in residential schools.

McEwan House helps people with HIV/AIDS who also suffer from a mental illness. The staff treat residents as whole persons who have both physical and mental health problems that cannot be viewed (or treated) in isolation from one another. In the case of people living with HIV/AIDS, too often they are told that their depression is simply a natural outcome of their circumstances – when depression is a treatable illness. The Adding Life to Years program out of St. Michael's Hospital encourages AIDS organizations to think about – and take steps to address – the mental health of their constituency.

This issue of *Network* also addresses the special mental

health needs of the Deaf community, where communication, that most essential ingredient of mental health care, is a complicated matter. Therapists who sign are rare, and experiences of being ignored or treated badly by the hearing community have left many Deaf people with a deep mistrust of those who have not directly experienced their culture and reality.

And finally, we feature the Culturally Competent Mental Health Project which provides mental health counsellors to settlement agencies in Toronto. New immigrants to Canada, who have very little English, who bring their own traumas with them, and who have limited support in their new country are at high risk of developing mental health problems – yet, where do they go for help?

In today's world, people have multiple identities that relate to race, ethnicity, culture, sexual orientation, language, talent, political affiliation, social cause, and spiritual beliefs. And even as I write, these categories are shifting. The idea of family is much broader than it once was and now includes almost unlimited variations of people living together, caring for one another and for children. People change careers often in their lifetimes, and we are a mobile population that has called many communities home at one time or another.

Nonetheless, how we define ourselves, our individually created identity, matters to our mental and physical well-being and requires acknowledgement when others are helping us heal from life's wounds.

# Personal

# P

*An  
Interview  
with  
Dr. Marie  
Bountrogianni*

# litics

The Honourable Dr. Marie Bountrogianni was elected to the Ontario legislature in 1999 and re-elected in 2003. During her first term, she served as opposition critic for colleges and universities and for women's issues. Currently she manages a double portfolio as Minister of Children and Youth Services and Minister of Citizenship and Immigration.

# F

From 1989 to 1999, Dr. Bountrogianni served as Chief Psychologist for the Hamilton-Wentworth District School Board and was an assistant professor in the Department of Psychiatry at McMaster University. An active member of her community, Dr. Bountrogianni was a director of St. Peter's Hospital in Hamilton from 1993 to 1998 and served as the hospital's vice-chair from 1995 to 1998. She was a member of both the Hamilton-Wentworth Regional Police Youth Crime Committee and the Bereavement Working Group in Hamilton. She has provided support to numerous community initiatives including serving as honorary co-chair of the Hamilton & Bay AIDSwalk and Grace Haven Capital Campaign. Dr. Bountrogianni and her husband, Dr. Ioannis Tsanis, a professor of engineering at McMaster University, have two children, Alexander, 16, and Joanna, 13.

**Even prior to your entry onto the political stage, you were a very active member of your local community. Where does that sense of commitment to the community come from?**

My sense of commitment to the community comes from being the daughter of immigrants and appreciating the country we live in, but also having a very strong work ethic, starting out in poverty and working very hard, and my parents were excellent role models for that. At the same time, they always, always appreciated their new country. They always gave back to their local community, which was basically the church, the Greek community. So I was involved from a very young age in teaching Sunday school, in volunteering in the Greek school – my mother was the teacher – and that just carried on. In high school I was volunteering as well, in a women's shelter, reading to disabled children. My mother ran a daycare centre, and there were many children on subsidy in that daycare centre, so we did a lot of extra things for those families. So I guess it's just the way I grew up.

**And then you went into psychology...**

Actually, I started out in engineering. In first year, I took Psychology 101 and then another psychology course, working with what we used to call juvenile delinquent girls. Of course, we call them young offenders now. I was working with young women who were only a couple of years younger than I was. I received excellent feedback from my supervisor that I was very good at it, and I enjoyed it very much. One of my high school teachers had said to me, before I went into engineering, "You should be working with people. You are made to work with people. Why do you want to design Coca-Cola machines for the rest of your life?" Now, I married an engineer, so no disrespect to engineers, but what my teacher said came back to me, so I switched in second year. I went into psychology because I really loved that experience, working with young women who were in trouble with the law. They were wonderful, sensitive young women who made a few bad choices, who in some cases had mental disorders and were, in a sense, being punished for it. I discovered that I had a special interest in children, and I went into child psychopathology and child psychology.

**And from there into politics. It seems a bit of a leap from psychologist to politician – what motivated you to become politically active?**

In 1994 the New Democratic Party was in power and both my parents were small business people. I felt that small business owners were treated unfairly. My own parents, and many of their colleagues, worked seven days a week, with no benefits, no vacation time, no sick days, and yet they were painted as greedy and rich. So I basically ran on that personal issue. To me it was a fairness issue. I lost that election, but I ran again in 1999. Between 1995 and 1999 I saw what was being done to health care and education by the Tory

I've worked with people with disabilities, children for the most part. But when you work with children you work with families, and you know that a disability affects the whole family, regardless of the age of the person with the disability.

government, so I ran again on those issues. I was the chief psychologist at a school board and I followed what they were doing to Special Education. I was vice-chair of a hospital and I saw what they were doing to health care. I was also teaching at McMaster, so again I saw what they were doing to post-secondary education. Tuition was going through the roof. Again, I saw really good reasons to put my money where my mouth was.

**How does your background as a psychologist inform how you do your present job?**

I feel like I've been training for this job all my life. In the Children's portfolio, for example, my public service staff tell me I don't need as much briefing as other ministers in the past, which is a compliment. It reflects my training, but also my interests, and my passion for children. My mother used to own a daycare centre, and now I'm in charge of child care in the province. I know those issues, I feel those issues. On this side, Citizenship and Immigration, I'm a daughter of immigrants, so I have a passion for integrating new Canadians and helping, with my colleagues, in ensuring that they work in the field of their profession, which is very difficult. I also have the *Ontarians with Disabilities Act*, and I've worked with people with disabilities, children for the most part. But when you work with children you work with families, and you know that a disability affects the whole family, regardless of the age of the person with the disability. Many times, mental health is ignored when we talk about disabilities. People think of wheelchairs, and of course physical accessibility is a very important issue, but to me it's just as important to think of mental health issues as well. We have consulted widely on the *Ontarians with Disabilities Act*, and I've always had mental health on the radar screen. I think that's partly my training as well.

**You have two quite different portfolios, each with very diverse constituencies. Have you identified any common threads or recurring themes across the two ministries?**

I think every minister should have two ministries, at least for a little while, tiring as it is, because there's a lot of over-



With the *Ontarians with Disabilities Act*, one of the first steps is ensuring that people with mental health disabilities have their human rights respected, and making them feel like they can be comfortable talking about their disability... We need to help people to advocate for themselves. In my career I've been doing that for children with learning disabilities, and children with depression, when I worked as a chief psychologist. And now I'm finding I have an opportunity to do it on a larger scale with my ministry.

lap. The problem is that we have in government artificial silos within ministries, which makes the overlap or implementation of any issues difficult. I'm really proud that in this government we have a lot of inter-ministerial committees. We're trying to break down those silos. So in my other ministry I'm working very hard with the minister of education to break down the silo for children's disabilities in the school system, and the autism strategy was the first step for that. In this ministry, I'm working very hard with Minister [Mary Anne] Chambers on foreign trade credentialing, working hard with Minister [Joseph] Cordiano for economic development, with Minister [Harinder] Takhar on transportation and accessibility issues, and on and on. We are working very well together. It takes longer, because meetings take time to set up, everyone is very busy, but at the same time, we do it right. And so I'm really proud of our government. It's the way I like to work as well, consulting before I do anything.

Yes, the two ministries seem very dissimilar, but there's a lot of overlap. I'll give you an example. When we had round tables on immigration to inform me for my immigration agreement with the federal government, we had one round table on immigration and children. Kids kept coming up in my other round table, so I thought, let's have one with children and immigration specialists to see what are the issues. Sexual exploitation of children is one issue that kept coming up. Domestic violence issues kept coming up. Interpretive services weren't available. We fund those through my ministry, so that women who suffer domestic violence and their children have an ability to communicate. The overlap is amazing. But you're right, on the face of it, it seems like two different ministries. And in implementation, the silos are there. Perhaps historically they're there for good reason, but breaking down those silos is something I'm determined to do.

**We live in a society that places a great deal of emphasis on the intellectual needs and physical development of children, but not an awful lot on their emotional well-being. Do you have any views on that?**

I have very definite views on that, as a psychologist and as a parent. You're right, we tend to value certain aspects of intelligence. My research area was in assessment of children from different cultures, and part of that was different types of assessment. I'm a big believer in Sternberg's theory of intelligence, or Howard Gardner's theory of intelligence, where it's multifaceted, where artistic ability, emotional ability, emotional IQ of course, has gotten some play in recent years. It's just as important. You see it in your everyday experience. You can have a very high IQ but if you don't have people skills, information and ideas will be difficult. Conversely, you can be like the majority of the population, of good high average IQ or even below that, but if you work very hard you can achieve miracles. So I think we have to recognize that a little more.

**What form would that recognition take?**

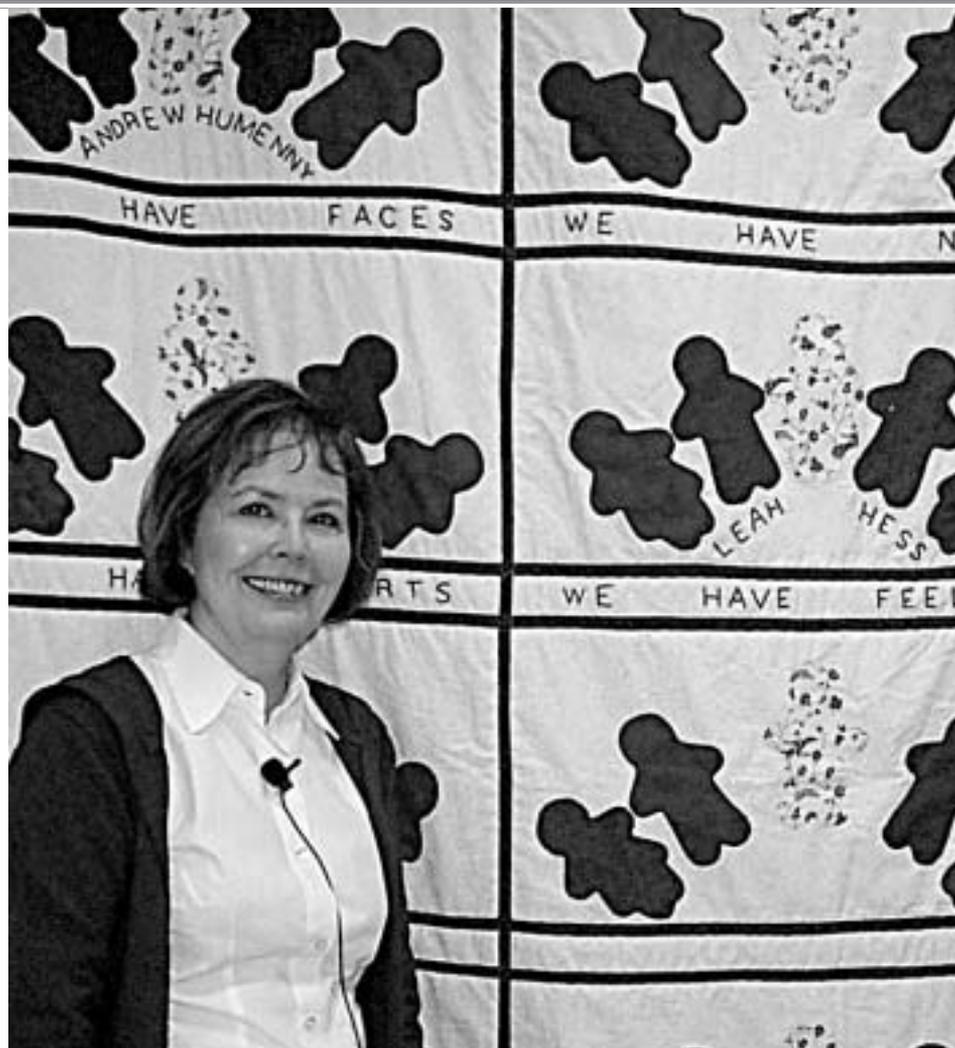
**What kinds of things could be done?**

I think basically in this Ministry of Citizenship and Immigration, with the *Ontarians with Disabilities Act*, one of the first steps is ensuring that people with mental health disabilities have their human rights respected, and making them feel like they can be comfortable talking about their disability. There isn't a stigma against physical disability, so to speak, but there still is unfortunately for mental health disability. So if you see someone who has mobility difficulties in the subway, you – not everyone of course, but generally – you look upon that person differently than someone perhaps who has a mental health problem and is talking to

himself loudly. You can just see it in the body language of people. We need to help people to advocate for themselves. In my career I've been doing that for children with learning disabilities, and children with depression, when I worked as a chief psychologist. And now I'm finding I have an opportunity to do it on a larger scale with my ministry. The autism strategy in my other ministry is another example of that. Children should be in the school system, regardless of disability. If the right supports are there, they should be in the school system. We doubled the money for autism and the majority of that \$40 million will be spent helping educators help children with autism. And I want to see that broadened across disabilities. The schools do a wonderful job, but there's still more expertise that is needed, and understanding.

**Project yourself into the future, and looking back on your time in office, what do you want your legacy to be?**

A lot of people ask me about the *Ontarians with Disabilities Act*. I mentioned that I was in engineering in 1975. I was at Waterloo, and if I had continued I would have been in the co-op program. There were some placements that were not open to me and my female co-students because they didn't have female washrooms. If you project back to 1975, and you think about what has changed since then, imagine if a female engineering student today came out to the media and said, "I can't go to that geology co-op because there isn't a women's washroom," I think there'd be bedlam. I would like in a few years for people to say, "Before this minister, people actually complained about the cost of a ramp, people actually complained that someone with Tourette's Syndrome could actually go into a restaurant," and I'd like them to say, "At least she made a really good impact on people, so that today we wouldn't even dream of that happening."



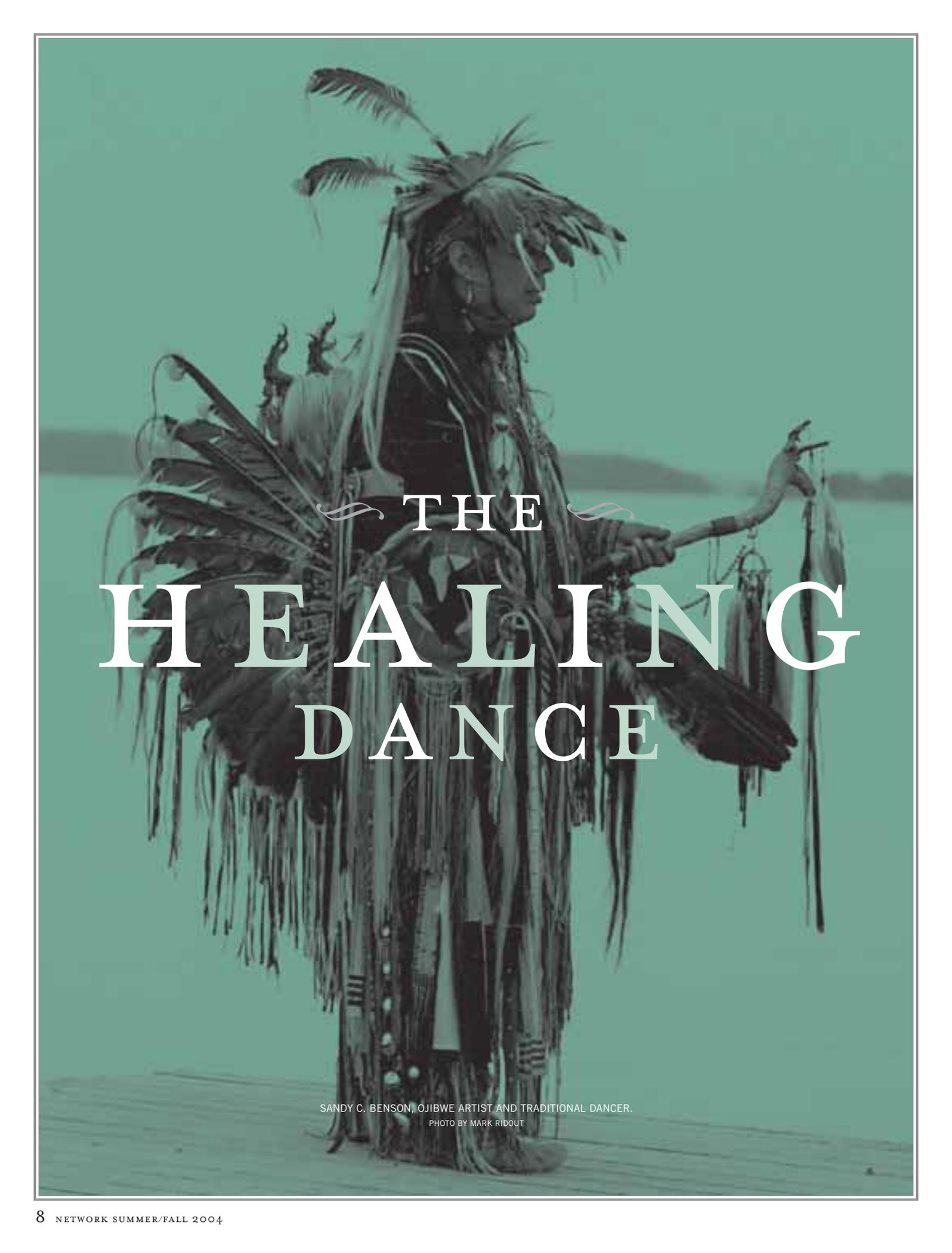
## Quilt of Honour

Susan Hess (above) is a parent of a child with mental illness. Together with quilter Joy Hansen, she created the Quilt of Honour to recognize and pay tribute to children who struggle with mental illness – those who are alive and those who have died. By persuading children and families to allow their real identities to be used, she hopes to remove the stigma of mental illness and let the power of the children's courage take centre stage.

The design of the quilt was inspired by the old-fashioned paperdoll chain. The red and white figures in the chain represent children. The figures holding hands represent children who have received help for their mental health problems. The figures standing alone represent children who are waiting for help. The white figures represent children who have taken their own lives.

As president of Parents for Children's Mental Health and a passionate advocate for children and their families, Hess now tours the province to display the quilt and raise awareness.

For tour dates and more information about the Quilt of Honour, call 416-921-2109 or visit [www.parentsforchildrensmentalhealth.org](http://www.parentsforchildrensmentalhealth.org).



THE  
HEALING  
DANCE

SANDY C. BENSON, OJIBWE ARTIST AND TRADITIONAL DANCER.

PHOTO BY MARK RIDOUT

A thousand First Nations and Métis people arrive from four directions across northwestern Ontario, gathering along the sandy shores at Migisi Sahgaigan (Eagle Lake) First Nation for the 22nd annual midsummer Gathering of the Eagles powwow.

Traditional Anishinaabe (Ojibwe) drums, their keepers and singers sit at the heart of the outdoor arena under a shaded arbour. From afternoon until midnight, hundreds of dancers in elaborate, rainbow-coloured regalia spill out onto the grassy dance area, joined in turn by visitors and spectators. The master of ceremonies encourages everyone to “dance your style.” Conversations and announcements can be heard in Anishinaabemowin (Ojibwe) and English. Friendly smiles greet familiar faces and newcomers alike.

A closer look at this gathering offers a glimpse of the many faces of healing among Aboriginal people in Ontario. People on a journey to health, much of it across rougher ground than the soft, inviting turf of the dance arena, a lot of it uphill, a long haul that began in the 1960s and 70s. For more than a generation now, Aboriginal people have been on a journey of healing and renewal, taking slow, self-determined steps. Now, First Nations and Métis are gathering strength, midway on a path to recovery from an era of oppression.

Since the signing of Treaty 3 in 1873, the Anishinaabe of this region have weathered more than a century of isolation and tyranny imposed by government and churches, convinced that Aboriginal people would eventually be better off if they became like white men. Identity, language and culture were eroded, autonomy diminished. The Indian Act ruled even the most basic choices that other Canadians took for granted – where to live, learn, work, hunt, fish, who to marry, how to speak and raise children. Indians could not vote, nor leave reserves without written permission. Over 100,000 Aboriginal children across Canada – 16,000 in Ontario – were pressed into

residential schools from the 1930s to 1970s. For most of the 20th century, ceremonial gatherings such as the one at Eagle Lake were forbidden by law.

“Gathering Strength” is the title of Canada’s Aboriginal Action Plan, published in 1997 by Indian Affairs and Northern Development. The plan follows the federal government’s “Statement of Reconciliation: Learning from the Past,” acknowledging the “negative impact” of government policies and assimilation practices and affirming Canada’s commitment to advance the well-being of Aboriginal communities. This commitment included \$350 million over five years to promote healing for survivors of residential schools, channeled through the Aboriginal Healing Foundation into community-based healing programs. Those programs have now begun to wind down, while the impact of colonization continues to be felt at the heart of Anishinaabe communities.

#### **In the East**

On the last evening of the traditional powwow at Eagle Lake, on the eastern edge of Treaty 3 territory, Arnold Gardner comes to the podium to address the crowd. He is Ogichitaa – leader and spokesperson for the chiefs of Grand Council Treaty 3, representing 28 First Nations spread across 50,000 square miles.

After thanking visitors and community members, his voice measured and heavy, he shares news of a tragedy from the day before. A young man, 19 years old, son of another well-known leader from further north, is on life-support in a Thunder Bay hospital. The details echo similar events in past months and recent years – violence, substance abuse, accidents, and suicides, mainly involving young First Nations men.

Gardner has given tobacco to one of the traditional drums, to request a healing song. He especially calls on the young people to hear his words.

Every Aboriginal community today, on and off-reserve, is primarily young:

60 percent of the population is under 25 years of age. And it is young people who are most at risk. The First Nations Indian and Inuit Health Branch of Health Canada tracks the statistics. The most common causes of death are injury, accidents, drowning, poisoning and suicide. And even though the last of the Indian Residential Schools closed in the 1970s, a staggering number of children and youth continue to be removed from their homes to foster care and youth corrections facilities.

#### **From the South**

Gilbert Smith comes to the microphone before the healing song begins. On behalf of one community where six young men have taken their lives over the past 18 months, Mr. Smith invites citizens from

Few in number, Elders and traditional healers quietly go about their work in every community, usually outside of organizations and offices. People call on them at home, offering tobacco and simple gifts to sit with them at kitchen tables, around a fire, in sweat lodges and ceremonies.

across Treaty 3 to another assembly in late August to gather strength and ideas to stop this cycle of self-destruction. Gilbert is a traditional drumkeeper, teacher and healer, but also works full-time at Anishinaabeg Counselling Services in Fort Frances on the southern border of Treaty 3, one of a number of Aboriginal agencies now providing mental health

support services in the region.

As the drum starts the healing song, Elder Ann Wilson, in her late 70s, of Rainy River First Nation also to the south, rises to her feet and makes her way into the dancing area with the help of a cane and women friends. She is determined to add her strength to the mass of people that have filled the dance area. Ann is known and respected across Treaty 3, Ontario and other parts of Canada, as a gifted teacher who somehow evaded residential school for a life on the land, steeped in the language and traditions of her ancestors.

Earlier that morning, a young Aboriginal woman, Danielle Morrison of Kenora, almost 18 and ready to leave home for university, was one of many who stopped by to visit at Ann's camp. She had dreamt of the Elder a few weeks

earlier, of wanting to take her along on a trip, but not having room. Ann talks to Danielle about being out in the world on her own, away from family and community. "There's many things you'll come across out there," she says. "You have to watch, to understand what is good and what is not, be patient, to know how and when to choose what to take in, what is right for you."

Ann speaks in English, knowing that few young people now speak the language of her heart, a powerful vivid language full of images and life. She speaks of the responsibility to live well, to treat every part of creation including ourselves with respect, as we are all connected in a delicate web. She looks upon every experience, even illness and death, as an opportunity to learn and

then to live life more fully, more wisely.

Few in number, Elders and traditional healers like Ann Wilson quietly go about their work in every community, usually outside of organizations and offices. People call on them at home, offering tobacco and simple gifts to sit with them at kitchen tables, around a fire, in sweat lodges and ceremonies.

### To the West

Newer, emerging Aboriginal health care services, such as Wassay-Gezhig Na-Nahn-Dah-We-Igamig, the Kenora Area Health Access Centre, bring the expertise of Elders and traditional healing practices together with Western mainstream medicine in a wide range of services to 14 First Nations and urban Aboriginal people. The centre is



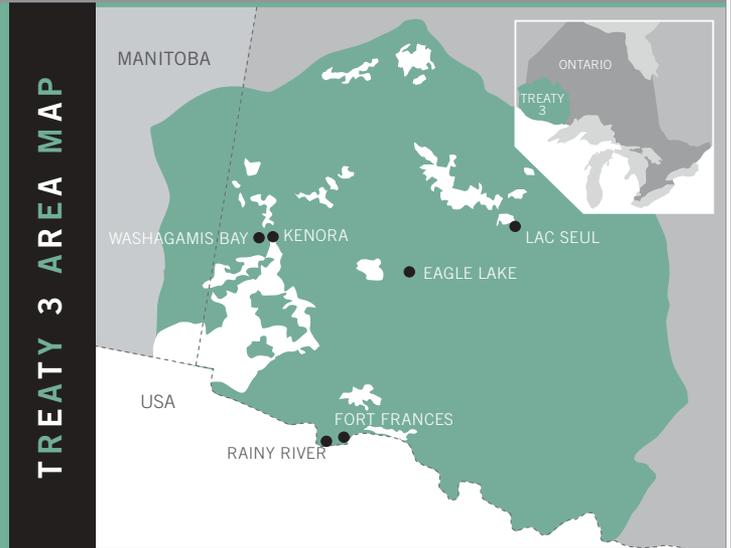
THE KENORA AREA HEALTH ACCESS CENTRE BRINGS TRADITIONAL HEALING TOGETHER WITH WESTERN MAINSTREAM MEDICINE. THE GROUNDS SURROUNDING THE MAIN BUILDING ARE AN INTEGRAL PART OF THE WORKING SPACE, WITH A SWEAT LODGE AND TEEPEE NEARBY.



## Aboriginal Identity

The Anishinaabe gathered at Eagle Lake represent a small portion of the 200,000 Aboriginal people in Ontario. One hundred and thirty-four First Nations dot the province, largely across the north, living on small reserves of 200 to 800 people. The population is increasingly mobile, shifting in greater numbers to urban areas for work, school, health care, social services and housing. In the northwest, Aboriginal people make up 10 to 25 percent of the population in small towns and cities such as Kenora, Dryden, Fort Frances, Atikokan, Red Lake, and Sioux Lookout. Aboriginal people are the descendants of the original inhabitants of North America. The Canadian Constitution defines "Aboriginal" to include Indians, Métis and Inuit peoples. In Ontario, Indian people and Métis are by far the largest groups. Since the 1970s, the term "First Nations people" has come into common usage as a replacement for the term "Indian."

Aboriginal peoples also identify themselves according to their cultural and national identities. In Ontario, these groups include Miyew (Cree), Anishinaabe (Ojibwe, Pottawatomi, Chippewas, Odawa, Algonquin and Mississaugas), Oji-Cree, Haudenosaunee (Iroquois-Mohawk, Onondaga, Oneida, Cayuga, Tuscarora and Seneca), Métis and Inuit. These identi-



ties are extremely important to Aboriginal peoples, and represent different heritages, languages, cultural practices, and spiritual beliefs.

For related links to First Nations resources, including information about residential schools, youth suicide, federal and provincial health strategies, and the Aboriginal healing movement, visit the CMHA, Ontario website at [www.ontario.cmha.ca/network](http://www.ontario.cmha.ca/network).

located in Washagamis Bay First Nation on Lake of the Woods. The grounds surrounding the main building are an integral part of the working space, with a sweat lodge and teepee nearby. Staff members include a physician, nurse practitioners, a diabetes nurse/educator, a nutritionist, a dental hygienist, a social worker, and a traditional healing coordinator. This recognition of Anishinaabe healing practices began in Kenora back in the 1970s with the Traditional Healers Program that operated out of Lake of the Woods District Hospital by Elders and healers, with the support of physicians and staff. Patients at the hospital could access traditional healing while getting mainstream medical treatments.

The Health Access Centre is one of an array of programs and services, from downtown Toronto to the James Bay coast, funded by the Aboriginal Healing and Wellness Strategy of Ontario. The AHWS, formed in 1994, “brings together Aboriginal people and the Government of Ontario in a unique partnership to promote health and healing.” The strategy directs \$33 million annually into First Nations and Métis designed health outreach, treatment and prevention programs. A “continuum of care... designed from the Traditional Medicine Wheel, it also addresses all age groups.” This summer the strategy announced an additional \$25 million in funding over five years, some of which will be channelled into mental health initiatives in the north.

Improving health remains one of the greatest challenges facing Aboriginal people. Even though gains have been made, people continue to live and die with infectious and circulatory disease, tuberculosis, respiratory illness, diabetes, dental decay, HIV/AIDS, at rates two to 20 times higher than national averages across age groups and gender. At the same time, employment, education and income rates remain significantly lower than for Canadians at large. Not even half of the houses in First Nations are connected to water treatment or sewage systems.

These realities take their toll on body, mind, heart and spirit. While



MARY ALICE SMITH (LEFT) AND LORRAINE KENNY IN JINGLE DRESSES AT THE EAGLE LAKE POWWOW.  
PHOTO BY CAROL TERRY

As a young mother, Lorraine Kenny struggled through years of panic attacks, anxiety, depression, and fear. With help she found ways to release pent-up emotions of grief and shame that kept her from a life she yearned for. Now she lives that life. In her late 40s, she fills her day with laughter, listening and healing adventures.

there’s been a return to sobriety and healthy living in many families, a lot of people continue to cope through poor eating habits, substance abuse, gambling and other addictions. Mental health professionals agree that the unusually heavy burdens of everyday life affect most people, showing in low-grade, chronic or situational depression and anxiety, attachment disorder, post-traumatic stress disorder and chaotic functioning. There don’t seem to be any quick cures for what social analysts refer to as “inter-generational trauma,” “ethno-stress,” and “ancient pain.”

Even with increasing numbers of staff and services, individuals and families tend to be more isolated from each other than in the past, more difficult to reach. “It’s hard to connect people in need of help with resource people in

their own communities,” notes June Mandamina, mental health worker and one of 50 staff at the Kenora Area Health Access Centre. Aboriginal health and social services are beginning to look at how to link up and cooperate more, network, and share resources. Skills training, information sharing, and mentoring are critical for the hundreds of front-line workers in small communities or organizations who try to carry the load on their own. As June says, “There’s lots of good people out there, they just need some support... We need to have someone go in and get people together to learn to work as a community or group.”

Little of this stress or isolation shows at Eagle Lake. Here the open expanse of sky and water add to an air of buoyancy. People are looking up and staying afloat in spite of the odds. Humour and hope

prevail. The Aboriginal Healing Foundation calls it “resilience.”

### Out of the North

Lorraine Kenny literally wrote the book on it in 2003 – “The Resiliency Workbook for Survivors of Residential School.” A decade earlier she compiled another manual, “Raising the Children: A Training Program for Aboriginal Parents.” She has spent her adult life learning to be the parent she never had, and sharing her stories of resilience with her own four children, grandchildren, brothers and sisters, and fellow survivors of residential schools.

With a grandchild in her lap, she reflects on her own journey to healing – and joy.

Lorraine’s mother died when she was only six at Lac Seul First Nation on the northern border of Treaty 3. She spent the rest of her formative years at Pelican Falls and then Cecilia Jaffray, two of the five Indian Residential Schools that operated in Treaty 3.

As a young mother, Lorraine strug-

gled through years of panic attacks, anxiety, depression, and fear. With help she found ways to release pent-up emotions of grief and shame that kept her from a life she yearned for. Now she lives that life. In her late 40s, she fills her day with laughter, listening and healing adventures. “I wake up every morning wondering, ‘What can I get into today...’”

Ms. Kenny coordinates the Bii Waasaya Healing Project, “coming into light,” a three-year residential school healing program funded by the Aboriginal Healing Foundation, working for the first time with her own First Nation at Lac Seul. Her hope for the community and other survivors of the schools is that they too will find their way to healing and joy. And that they will find inspiration as she does, in the eyes of the children.

### Closing the Circle

Events like the one at Eagle Lake offer a pause along a sometimes daunting path for Aboriginal people – time to reflect and celebrate, to connect and

renew, to learn and laugh, to gather strength. These gatherings offer a model to continue the journey, making room for everyone – women and men, young and old, Aboriginal people and newcomers, traditional knowledge and modern practices. The circle makes it easy to look back and ahead while carefully paying attention to the present. Each person, family and community, together, “dancing their style.”

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Mary Alice Smith, or “Kokum Sam” as she is known to her family, spends much of her time learning and sharing with others about how to “get along” in life. She has a BA in Conflict Resolution and 30 years of experience in community development and adult education with First Nations and Aboriginal organizations. A Métis (European-Cree) and lifelong resident of northwestern Ontario, Mary Alice lives near Kenora on the shores of Longbow Lake, where she enjoys gardening, walking, writing and jingle dress dancing.

## Where Are the Children?

Established in 1831 for children of the Six Nations Iroquois living on the Grand River, the Mohawk Institute was one of the first residential schools in Canada. “Although the residential school system had largely closed down by the 1970s, its legacy of systemic abuse of Aboriginal children is still felt today. The schools’ legacy also has had an inter-generational impact on today’s Aboriginal youth, and the children and grandchildren of former students.” – Jeff Thomas, Iroquois (Onondaga), guest curator of *Where Are the Children? Healing the Legacy of the Residential Schools*, an exhibition organized by the Aboriginal Healing Foundation and the National Archives of Canada. Following stops in New Brunswick and Manitoba, the travelling exhibit will be on display at the Multicultural Association of Northwestern Ontario in Thunder Bay from March 22 to July 29, 2005.



GRADUATES OF THE MOHAWK INSTITUTE, BRANTFORD, ONTARIO, 1880 (DETAIL).  
LIBRARY AND ARCHIVES CANADA, C-085134.



## Different Disabilities

What defines a disability? When we think of being disabled, we often think of people who use wheelchairs or other assistive devices for their physical needs. But mental illness can also be very disabling. Severe mental illness in particular can prevent a person from participating fully in various activities of daily living.

“Unlike a physical disability, such as blindness or being in a wheelchair, people can’t necessarily see that you have a mental illness,” says Karen Liberman, executive director of the Mood Disorders Association of Ontario. “I think it’s important to define mental illness as a disability so that we can be assured that people are given due protection under the law. For example, under the *Ontarians with Disabilities Act*, we’re according people certain rights, certain accommodations, certain protections. Unfortunately, I think people with mental illness would be ignored if they weren’t included as persons with disabilities under the Act.”

DEFINING MENTAL ILLNESS AS A DISABILITY IS IMPORTANT, SAYS KAREN LIBERMAN, EXECUTIVE DIRECTOR OF THE MOOD DISORDERS ASSOCIATION OF ONTARIO.

Visit Network online for the complete article, “Different Disabilities: Defining Mental Illness as a Disability,” as well as an annotated list of related resources.  
[www.ontario.cmha.ca/network](http://www.ontario.cmha.ca/network)

# Family Matters

People with mental illness often need a great deal of love and support from family members. At the same time, caring for someone with a psychiatric disorder can be very stressful. Family members and caregivers need to understand the illness, learn how to cope with unusual behaviours and solve difficult problems, and still remember to take care of their own health.

Launched in May 2004, during National Mental Health Week, a new section on the Canadian Mental Health Association, Ontario website provides invaluable information and advice for family members, friends and caregivers of people with mental illness. Resources include answers to frequently asked questions, a directory of self-help and support groups for family members in Ontario, and links to other online resources. An annotated reading list recommends books and articles from professional journals on a range of topics, including family psychoeducation and family

members’ roles, stigma by association, and research on the experience of caregivers, siblings, children, teens, adult children, parents and partners.

The Family Members and Caregivers Resource Centre was developed for CMHA, Ontario by staff member Colleen Moore, founder of the support group Help and Education for Loving Partners of people with a mental illness (HELP). The new section will continue to be updated over time, and visitors are invited to submit questions to be addressed in the FAQ, suggest resources, and contribute their personal stories of hope.



[www.ontario.cmha.ca/family](http://www.ontario.cmha.ca/family)

# Welcome to the Homeless Maze

**INSTRUCTIONS:** You must find food and shelter, get social assistance until you get a job, get health care as needed, find transportation, budget your money wisely, and eventually find stable housing. But you've lost your I.D., you only have \$35 in your pocket, it's November 15, and Christmas is coming. What you need to do is prioritize!

Note: Answers shown in brackets represent costs and services for a particular community within Ontario and may vary from area to area depending on what local services are available.

Created by Cornerstone Community Association in Oshawa, the Homeless Maze is an interactive and award-winning educational workshop that helps dispel the myths and stereotypes surrounding homelessness. Workshop participants have two hours to complete the maze - in reality, it can take up to six weeks to complete all the activities. For more information about the workshop, call Len Perkins at 905-433-0254 ext. 234 or visit [www.homelessmaze.com](http://www.homelessmaze.com).

Illustration by Jason Schneider. Copyright © 2004 by the Canadian Mental Health Association, Ontario. All rights reserved.

## Find A Job

What do you need to search for employment?

- Newspapers and Internet access, a telephone, a resume and a mailing address

What do you need to work?

- Education and work experience, or new skills training
- Daycare for your children
- Clean clothes, haircut and a shower



## Find Emergency Shelter

Do you know where the local shelter is?

- How long can you stay? (14 days)
- Will they feed you? (3 meals/day)
- What about money? (\$3.70/day needs allowance)
- What if you have children? (men and women may have to sleep in separate shelters, so families can't always stay together)

Is it safe to sleep on the street?

- It's late and the temperature is dropping...

## Find Food

- Is there a local soup kitchen?
- How often can you eat there? (once a day)
  - Is there a cost? (\$1.25)
  - When is it open?

- Is there a food bank in your community?
- How long will your bag of food last? (3 days)
  - How often are you allowed to visit? (once a month)
  - When is it open?
  - How will you carry the heavy bags home?
  - Can you pay for transportation?

## Budget Your Money

You can apply for social assistance, but...

- You need your SIN card
- A single person on basic assistance gets \$520/month
- After rent (\$400), you have \$3.40/day to pay for food, clothes, transportation, personal needs, etc.

You don't have access to a bank account

- Where do you cash your cheque?
- Cheque-cashing service charges an \$18 service fee for cashing a \$520 cheque



You are Tara Doe, 28 years old, grade 11 education, with two children (ages 2 and 7) and no family support. You have left your husband, who physically assaulted you, and you have no safe place to go...



You are Harold Doe, a 62-year-old widower. A stroke last year left you with physical disabilities that prevent you from working. You're on medication for stroke and diabetes. Your employment insurance has run out, you're behind on your rent, and you're being evicted today...

## Find Stable Housing

- Rent-Geared-to-Income Housing
- Waiting list is 3 to 7 years. Good luck!

## Get Health Care

- You need a health card
- ER will take you without ID, but there's usually a long line-up. Private clinics require ID.
- Do you have a mental illness?  
• Medication for depression, anxiety, and other mental health problems can take months to get right
- Do you need eye care? (not covered by social assistance)
- Do you need a dentist?
- Do you need treatment for substance abuse?

## Replace Lost ID

- Health Card
- Free, but you must have a birth certificate
- Birth Certificate
- Takes 18 weeks and costs \$35
- Emergency two-day service costs \$50
- Social Insurance Number
- New SIN card costs \$10

## Short-Term Housing

- Rooming House
- Landlord demands money in advance for rent (\$400/month)
- Proof of eligibility for social assistance required (see your social worker to apply)
- Is it near public transportation?



You are John and Sue Doe, with three children (2, 8, and 14). Joe lost his job last year, and Sue is a stay-at-home mom. Joe's severance has run out and he can't find work. You're months behind on your mortgage payments, and the bank is foreclosing. You have to be out of the house in 3 days...



You are Kelly Doe, 18 years old, and you suspect that you're pregnant. You just moved out of your alcoholic mother's home because your stepfather physically assaulted you. You've dropped out of school to look for a job, but you have only grade 9 and no work experience. You've worn out your welcome at the friend's place where you've been staying...

# C O N N E

*with the*

# D E A F

community



MISUNDERSTANDINGS OF DEAF CULTURE AND A LACK OF SIGN-LANGUAGE INTERPRETERS ARE ONLY TWO OF THE BARRIERS FACED BY PEOPLE WITH HEARING LOSS WHEN THEY TRY TO GET HELP FOR THEIR MENTAL HEALTH NEEDS. A RECENTLY EXPANDED PROGRAM IN ONTARIO IS BEGINNING TO OVERCOME THOSE OBSTACLES.  CONNECT COUNSELLING SERVICES IS A PROGRAM OF THE CANADIAN HEARING SOCIETY (CHS). THE SERVICE HAS BEEN IN TORONTO SINCE 1986, BUT LAST YEAR RECEIVED FUNDING FROM THE MINISTRY OF HEALTH AND LONG-TERM CARE TO EXPAND ACROSS THE PROVINCE. IT IS NOW AVAILABLE IN ALL REGIONAL OFFICES AND SOME AREA OFFICES.

# CONNECTING



The program is free and open to any person with hearing loss, regardless of age. Staff members include counsellors, case managers, community outreach workers, and mental health sign-language interpreters. Staff are qualified professionals who are hearing, deaf, and hard of hearing. They work with people with severe mental illnesses, such as schizophrenia or bipolar disorder, as well as anyone who needs general counselling, including family members. CONNECT also offers public education workshops and provides consultation to service providers to increase sensitivity and awareness of the mental health and access needs of deaf, deafened and hard of hearing people.

The CONNECT counsellor in the London office is Rebecca Grundy. She is a social worker who has worked with CHS for 12 years. Grundy offers individual, couple, family and group counselling, and works with all consumers and their families around education, advocacy and support. If necessary, she may also refer her clients to a psychologist or help them ask their family physician for a referral to a psychiatrist.

Grundy explains that there is more than one group within the deaf commu-

nity. There are people who were born deaf and see themselves as members of a distinct community – often denoted by capitalizing the first letter in “Deaf” – and there are those who lost their hearing, gradually or suddenly, later in life. Grundy says this distinction is important. “Their mental health and access needs are very different,” she says.

Deb Selwyn, who works with Grundy as a consultant, agrees that people in the deaf community face a variety of challenges. Selwyn is a community support coordinator for the London-Middlesex branch of the Canadian Mental Health Association. She says that many people in the deaf community are unaware that counselling services are available. “Often they don’t even understand what counselling means,” she says, “because it has never been provided to them.”

Gaining access to health care depends on being able to communicate. Studies show that approximately 45 percent of deaf patients who have seen doctors without interpreters have medical problems that remain undiagnosed. The shortage of sign-language interpreters in Ontario is a major barrier, Selwyn says. Even though the government is required to provide an interpreter for medical appointments, there are not enough to go around.

As well, having an interpreter sit in

for a counselling session can be intimidating, especially if very personal issues are being discussed. “If it is something really significant, like in the post-trauma population where women are discussing abuse and horrific things that have happened to them at a very young age,” explains Selwyn, “you are telling it not only to the counsellor, whom you don’t know and who is from another cultural background, but also to a third person, and that process is so intimidating.”

Dr. Cathy Chovaz McKinnon, a clinical psychologist who works with the deaf community, says that using an interpreter in a counselling session is doubly difficult because the deaf community is small and well connected. The client may be relying on an interpreter they know personally, making it hard to freely disclose sensitive information. Dr. McKinnon, who is herself deafened and fluent in American Sign Language (ASL), has an advantage in being able to work without an interpreter. But her situation is rare.

In her submission to the Romanow Commission, Dr. McKinnon wrote, “It is common for Deaf individuals not to have a family doctor given the huge barriers inherent even in phoning for an appointment, let alone trying to communicate with the doctor.”

Aren't there other ways for health care professionals to communicate? Written notes may be the most frequently used method, but they are time-consuming, impractical, and largely ineffective, since only 12 percent of the deaf population is fluent in English. The average pre-lingual deaf person – that is, someone who is either born deaf or loses their hearing before language is acquired – reads English at a grade three to six level, regardless of intelligence.

“Reading and writing in English isn't a good way to communicate about these types of issues,” says Grundy. “People may not know the English term. The language is just very, very different. It's a little bit like an immigrant coming over into our community and not knowing

“It is critical that the clinician have a good understanding of Deaf culture in order to appropriately recognize symptoms, diagnose disorders, and plan for treatment within the patient's context.”

English. It's difficult to communicate what your needs are and what your emotional experience is.”

“We use a variety of methods to communicate,” explains Grundy. “If I have a deaf person who signs, quite often I sign myself. But if I'm meeting with a family, for example, that's too much for me to be able to sign and provide the therapy at the same time, so I'll have a sign-language interpreter for that situation. If I have a deafened person who understands English, then I'll type while I talk so they can read what I'm saying. If it's a hard of hearing person, then we have different choices. I can either type while I talk, or there are some amplification devices that I can use, or I can give them certain keywords, so they can follow my conversation easier. So for each person it may be different. We identify the best way to communicate, and then I adapt to their needs.”

Another obstacle is the deaf community's mistrust of the hearing community. Dr. McKinnon explains some of the reasons for this mistrust. “There is an extensive history of oppression, whereby deaf people were considered ‘dumb’ and unable to function in society as intact individuals.” There is also a history of physical abuse, notably by hearing adults who take advantage of the vulnerability of deaf children who “can't tell,” says Dr. McKinnon. “This legacy has unfortunately been found in many schools for the deaf, as well as out in the community.”

Cultural differences add to the mistrust. “It is critical that the clinician have a good understanding of Deaf culture in order to appropriately recognize symptoms, diagnose disorders, and plan for treatment within the patient's context,” says Dr. McKinnon. To illustrate her point, she gives the example of an inexperienced counsellor thinking that a person is agitated or manic because they are signing rapidly, when in reality it's just a function of the language (ASL). Or the counsellor may think that someone who doesn't make eye contact is simply shy. In fact, eye contact is a very important aspect of Deaf culture and an integral part of

ASL. The absence of eye contact could indicate a trust issue or have many different diagnostic implications.

Linguistic barriers also present a challenge for mental health professionals working with deaf clients. Selwyn uses the example of a deaf person being asked if they are hearing voices during an assessment for a psychotic episode. “You'll never get an accurate response to that question, because you're asking a deaf person if they're hearing,” she says. Deaf people don't understand the question in the same way that hearing people do. If they answer yes, it may be because they are hearing residual sounds. But if they answer no, they may be released from hospital with an inaccurate diagnosis.

Lack of respect from people who don't understand can isolate and ostracize deaf people from the larger community. “The self-esteem of a person with hearing loss tends to be chipped away at so much that they can become very depressed,” says Grundy. “They may withdraw from society, stop going out in the community, or stop socializing with friends.” People who lose their hearing later in life tend to get depressed because they have to redefine themselves and learn the basics over again.

“There is a great need for our service,” Grundy continues. “If you think about most services that people go to, it's a lot of talk therapy, and when your communication is different or troubled, or you don't have the ability to hear the person, that impacts all the treatment you receive from professional services.”

“The mental illnesses themselves are not unique to our community. It's the same across all communities. The problem for deaf and hard of hearing people is access to services.”

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For more information about CONNECT Counselling Services, visit the Canadian Hearing Society website at [www.chs.ca](http://www.chs.ca), or call 416-928-2500 ext. 250 (phone) or 416-964-0023 (TTY). For more about Dr. Cathy Chovaz McKinnon, visit [www.deafpsych.com](http://www.deafpsych.com).



DR. CATHY CHOVAZ MCKINNON IS A CLINICAL PSYCHOLOGIST WHO WORKS WITH THE DEAF COMMUNITY.

# UN D FOU IN

## TRANSLATION

PARVEEN'S HUSBAND KICKED HER OUT OF THE FAMILY HOME IN THE MIDDLE OF THE NIGHT. A NEW IMMIGRANT TO CANADA FROM PAKISTAN, PARVEEN (NOT HER REAL NAME) WAS SUFFERING THE EFFECTS OF TRAUMA FROM HER ABUSIVE HUSBAND AS WELL AS THE SYMPTOMS OF SCHIZOPHRENIA. "SHE DIDN'T HAVE ANY SUPPORTS, SHE HAD NOWHERE TO GO," SAYS GULSHAN ALLIBHAI, COORDINATOR OF CROSS-CULTURAL INITIATIVES AT THE CANADIAN MENTAL HEALTH ASSOCIATION (CMHA), TORONTO BRANCH. "SHE ENDED UP ON THE STREETS, SHE ENDED UP HOMELESS."

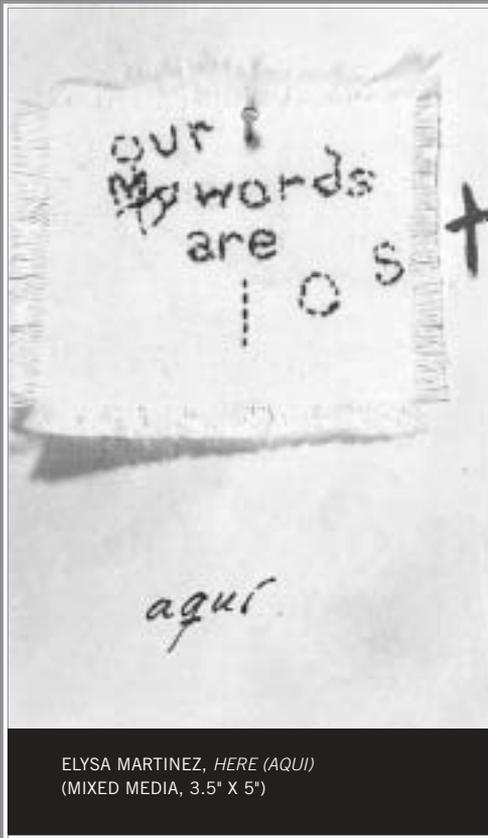
**S**peaking only Urdu, Parveen still managed to find her way to a homeless shelter. The staff there connected her with the South Asian Women's Centre, a settlement agency run for and by South Asian women. As a result of a new cross-cultural program led by CMHA Toronto, the women's centre can afford a part-time mental health worker on staff. The worker was able to offer support to Parveen in her own language and connect her with other services.

"Without this project," Allibhai says, "Parveen wouldn't have been able to get the extra mental health support that she needed."

The Culturally Competent Mental Health Project was created to improve access to mental health services by placing mental health workers in each of three settlement agencies serving immigrants and refugees. Funded by the New Trillium Foundation, with additional money from the United Way of Greater Toronto, the project is a partnership among CMHA Toronto, Community Resources Consultants of Toronto, the Afghan Women's Counselling and Integration Community Support Organization, Polycultural Immigrant and Community Services, and the South Asian Women's Centre.

This project, and similar work taking place around the province, was inspired by the growing cultural, racial, religious, and ethnic diversity of Ontario's cities and communities. Mental health providers are changing and growing to meet the need for "culturally competent" mainstream services where professionals recognize and can respond to the specific challenges faced by newcomers and ethnoracial communities.

Although most newcomers successfully establish new lives in Canada, many



ELYSA MARTINEZ, *HERE (AQUI)*  
(MIXED MEDIA, 3.5" X 5")

face significant obstacles that have an impact on their mental health. Some have survived traumatic events, including war, civil unrest, or torture. Others face resettlement stress as a result of losing their former economic and social status, encountering racism, or having no access to community supports.

The CMHA Toronto project is a three-year initiative, begun in November 2003. It follows on the heels of two other successful partnerships with settlement agencies, Building Bridges and Breaking Barriers. In these previous health promotion projects, the groups collaborated to create a variety of educational materials about mental health and mental illness. Brochures, workshops, newspaper articles, radio broadcasts, and theatre performances were produced in Farsi, Greek, Hindi, Polish, Tamil, Urdu and other languages. According to Allibhai, this outreach led the partners into taking the next step together. "Now that we've done all the mental health promotion, and we have people who have mental illness learning about this," she explains, the question became, "What are we going to do now?"

Toronto is one of the most multi-cultural cities in the world, with immigrants from over 160 countries. The current project focuses on the Afghani, Pakistani and former Yugoslavian communities. "The settlement agencies," explains Allibhai, "identified these three as needing a lot of mental health services due to political unrest, resettlement stress, and trauma issues."

The settlement agencies already offer practical resources to newcomers from these communities, including English-as-a-second-language classes, help in finding work and housing, and social support. But they don't have the funding or the resources to provide more in-depth counselling or mental health services to their clients, and they face barriers in referring people to mainstream mental health services. Some newcomers won't go to a mental health agency because of the stigma associated with mental health problems. Another barrier is the lack of mental health staff who speak the client's language or who understand the specific mental health problems faced by newcomers.

"What this project does," says Allibhai, "is offer [settlement agencies] a position of a mental health worker who can support people who are going through resettlement stress." The workers provide supportive counselling to newcomers in their own language. They also refer people to other services including housing, support for women leaving abusive situations, and social and community programs.

"The biggest difficulty is the language barrier," says Bora Todorovic. He puts in 15 hours a week as the mental health worker at Polycultural Immigrant and Community Services, serving the communities of the former Yugoslavia. One of the resources he can offer people is a list he has compiled of over 20 psychiatrists in Toronto who speak Serbian, Croatian or Bosnian.

All three mental health workers are members of the communities they work with, and they speak the same language. For Allibhai, this "negates the linguistic barriers" and "breaks

down some of the cultural barriers because people are being helped by someone who may understand their worldview around mental illness."

Steve Lurie, executive director of CMHA Toronto, believes it's important to provide equal access to services for communities whose concept of mental illness may differ from the traditional Western understanding. "Every community identifies behavioural issues that stem from some definition of mental illness, whether it's a spiritual definition or a clinical definition," he explains. "[But] at some point, people say, 'We need help, and we may try the indigenous assistance within our community or we may go to the local hospital or CMHA.'"

One of the key barriers for newcomers who have a serious mental illness is the difficulty of navigating a complicated and fragmented mental health system. At the point where they need to connect with mainstream mental health services, "the mental health worker is their link to services here at CMHA," says Allibhai. The mental health worker can provide language assistance and help other mental health professionals understand their clients' cultural needs and mental health issues. "The mental health worker can stay in the loop and be an advocate, so that people aren't falling through the gap."

Raising awareness within their communities is a key part of the job. "To educate people about mental health, that's my main purpose," declares Subuhi Jaffrey, the mental health worker at the South Asian Women's Centre. "It can be very difficult to convince them, to bring them out of their shell," she says. Jaffrey feels that stigma plays a role in people's unwillingness to seek out help, as "mental health means something wrong to them, such as abuse." As well, people may have their own coping skills and may not feel they need professional help. "They self-treat, using things like homeopathic treatment."

Similarly, immigrants from the former Yugoslavia are "hesitant to ask for

help,” says Todorovic. The people he serves have significant mental health issues related to the impact of war and civil unrest in their homeland. They are often described as an “orphan community” by mental health and settlement professionals, as so few services are directed to them, despite the evident need.

The three mental health workers don't simply wait for people to find them. Instead, they use a variety of strategies to reach out to their communities. Jaffrey, who is Muslim, has introduced herself and the project to imams at mosques and other community leaders. “It can be a difficult thing to reach people in the Muslim community,” she says. “Ladies, in particular, feel ashamed.” Imams often provide counselling and support, and she encourages them to consider referring people to her by explaining that different people can play different roles in supporting people with mental health problems – “the imam in the mosque, the psychiatrist in the hospital, and the mental health worker in the community.”

Todorovic uses a variety of media to reach people. He runs ads and writes articles in local ethnic-language newspapers about mental health issues and how the project can help. He will also appear in the fall on a cable television show geared to viewers from the former Yugoslavia.

Both Jaffrey and Todorovic stress the importance of the personal connections they make with people. Jaffrey describes her experience with one woman who was referred to her from a local hospital. She was told that the woman “doesn't

Although most newcomers successfully establish new lives in Canada, many face significant obstacles that have an impact on their mental health. Some have survived traumatic events, including war, civil unrest, or torture. Others face resettlement stress as a result of losing their former economic and social status, encountering racism, or having no access to community supports.

like to talk,” but Jaffrey visited the woman at home, made a personal connection, and the woman opened up to her. Todorovic, who trained in the former Yugoslavia as a medical doctor and then learned to speak English after arriving in Canada two years ago, feels that his own experience as an immigrant helps him to connect with his clients, so that their fear of getting help for mental health problems is overcome.

Despite the fact that funding for staff time is limited and getting word about the project out to different communities can be challenging, Allibhai says they were “shocked” that so many people accessed their services within the first year of starting the program. Each of the three mental health workers is now supporting from 10 to 36 clients.

Golali Nawabi is the only full-time mental health worker with the project. She works with women and men from the Afghani community at the Afghan Women's Counselling and Integration Community Support Organization. She works in partnership with the other

mental health agency in the project, Community Resources Consultants of Toronto. The success of her work, and the need for her services, is shown by the fact that she now has 36 people on her caseload and has had to start a waiting list.

CMHA Toronto's Culturally Competent Mental Health Project is only one of several outreach activities in the mental health community attempting to meet that demand. The Mood Disorders Association of Ontario has recently begun to partner with agencies that serve ethnocultural communities in the Greater Toronto Area to promote their self-help groups and other programs. They also offer training to help ethnocultural agencies develop their own self-help groups.

Recognizing and valuing diversity has become a priority for the Centre for Addiction and Mental Health (CAMH), a large public hospital located in Toronto, with community offices throughout the province. Their Building Bridges Breaking Barriers project is a joint initiative with five



MEMBERS OF THE JAMAICAN CANADIAN ASSOCIATION PERFORM *GRANNY GONE CUCKOO*, A SHORT PLAY ABOUT OVERCOMING CULTURAL MISUNDERSTANDINGS OF MENTAL ILLNESS. THE PERFORMANCE TOOK PLACE IN MAY 2004, DURING THE 50TH ANNIVERSARY AGM OF THE CANADIAN MENTAL HEALTH ASSOCIATION, TORONTO BRANCH.



GULSHAN ALLIBHAI, COORDINATOR OF CROSS-CULTURAL INITIATIVES AT CMHA TORONTO.

One of the key barriers for newcomers who have a serious mental illness is the difficulty of navigating a complicated and fragmented mental health system. Mental health workers can provide language assistance and help other mental health professionals understand their clients' cultural needs and mental health issues. "The mental health worker can stay in the loop and be an advocate, so that people aren't falling through the gap."

ethnoracial and cultural agencies, designed to ensure that members of those communities have full access to mental health and addiction services at CAMH. Recommendations from participants in the program have now been incorporated into day-to-day services, with plans to expand the project into other communities and programs within the Centre.

The goal of many of these projects is to change the way mental health organizations offer support and services. CMHA Toronto has been engaged in the process of organizational change since the late 1970s, when they began reaching out to specific ethnocultural and racial communities. Today, CMHA Toronto offers a wide range of culturally competent programs, including specialized case management services for people with serious mental illness from the Tamil and Somali communities and for French and Italian speakers. Lurie and Allibhai view their work as an ongoing learning experience. Says Lurie, "You have to be constantly asking within the organization, 'How do we ensure that we're sensitive to the issues of diversity and culture?'"

"Our staff need to be at a level where they're going to be able to understand and assess for migration stress and trauma issues, to look for the experiences refugees and immigrants have gone through," says Allibhai. She trains CMHA staff and other professionals to use culturally sensitive mental health assessment tools. According

to the definition developed by educators for the Building Bridges project, "the culturally competent helper understands that newcomers face challenges in adjusting culturally, linguistically and economically to Canada."

Comparing today's mental health services with what little existed when she and her family came to Canada as refugees from Uganda in 1972, Allibhai remarks, "At least we have some now. But if you look at the span of things, that's 32 years ago, and we've maybe moved inches."

Both Lurie and Allibhai stress the need to continue pushing on both fronts – to increase the cultural competence of all staff working within men-

tal health agencies, and to build partnerships with ethnoracial community groups to increase their capacity to offer support and referrals. "Maybe because of the concern of confidentiality, maybe [because] it's a smaller community where everybody knows everybody," says Allibhai, some people prefer to visit a CMHA. Other members of the community, she continues, "only want to go to a language- or culture-specific agency, so you have to give people that choice."

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For more information about CMHA Toronto's cross-cultural initiatives, visit [www.toronto.cmha.ca](http://www.toronto.cmha.ca).

## Culture by Numbers

Toronto has been called the "world within a city." According to city officials, people from 169 countries have made Toronto their home. Almost half of these newcomers, 43 percent, arrived in Canada since 1991. In 2001, the largest number of immigrants to Toronto came from China, India, Pakistan, Philippines and Sri Lanka. In the home, 29 percent of Torontonians speak a language other than English or French.

Numbers, however, only tell part of the story. People's mental health is shaped by many factors, including economic, social and political status. Ethnocultural and newcomer communities are often marginalized, without access to adequate housing, income, employment, and education, all of which are recognized as key determinants of health. Education and employment skills gained in their home country may not be formally recognized in Canada, so that many people end up in low-paying jobs that don't reflect their training.

Lack of employment opportunities contributes to high rates of poverty. More than 34 percent of non-European ethnoracial families in Toronto live in poverty, at least twice the rate for European and Canadian-born people. Despite the fact that visible "minorities" make up almost 43 percent of Toronto's population, many are still confronted by racism and discrimination in housing, education, employment and other important areas of life, often with a negative impact on their mental health.

# Bridging the Gap



## HIV/AIDS AND MENTAL ILLNESS

Though it's just a few blocks from Toronto's busiest intersection, McEwan House seems miles away, on a quiet and shady residential street. There's nothing unusual about the look of the red-brick house, but despite its inconspicuous exterior, McEwan House is unique. It provides residential and community support for a group of people who are often overlooked – people living with both HIV/AIDS and mental health or addiction issues. This group exists between two worlds, but there are some committed individuals who are working hard to bring those two worlds together.

The community health needs of people living with both HIV/AIDS and mental illness often fall into the gap between the work of AIDS-service organizations and that of mental health agencies. Both service providers share many of the same philosophies, such as health promotion and harm reduction, and the people they serve face many of the same challenges, including poverty, stigma and isolation. Nonetheless, the HIV/AIDS sector and the mental health sector have not yet been able to bridge the gap between them. As Jim

## People living with HIV/AIDS often find that taking care of their own mental health becomes secondary to managing HIV, which in itself is a complex task.

Nason notes, the two worlds of HIV/AIDS and mental health “are definitely silos.”

Nason is the director of adult programs for LOFT Community Services, the organization that runs McEwan House. He worries that many people facing these two difficult health challenges aren't getting the support they need. McEwan House is one of the few places that bring these two worlds together.

McEwan Housing and Support Services actually operates from four different sites, and currently provides support for 21 people in residential programs and 60 people in community-based programs. The programs run the gamut from 24-hour supportive care to independent living in separate apartments, and from peer support to goal-setting, skills teaching, and linking to resources in the community. As new medications for HIV have been introduced, the program has adapted to place more emphasis on rehabilitative needs, including self-care, medication regimes, and household management.

“One of the real philosophies of McEwan House is that it's people's home,” says Nason. “In all the sites, there's a real sense of home. People come and go as they like, and staff are only there when they're needed. We try to stay out of people's faces. That's the juggling act.”

John, who has lived at McEwan House for three years, agrees. He sits in the quiet kitchen and speaks intently about what it's like to live here. “This is a good place for psychosocial [rehabilitation]. They deal with not only physical but emotional issues. I've never had that kind of care before.”

John struggles with both mental health and addiction issues, as well as HIV/AIDS, but like everyone else in the house, his journey and his story are his alone. HIV/AIDS presents unique challenges to everyone living with the illness. “This disease is tailored to the individual,” notes Steve, a seven-year McEwan House resident. Naming other residents, he continues, “My problem isn't Robert's, isn't Don's.”

Steve has created his own plan that is as individual as his experience, although his goals are often similar to those of other residents. Topping his list is the wish to secure independent housing, and to join the 80 or so members of the General Residents Association – people who no longer receive services at McEwan House, but continue to return for social events and other activities.

The planning process is a positive one, according to Steve. “It causes staff and myself to focus on what my goals are and

to do something to bring them about,” he says. “One of my objectives is to get housing outside of McEwan House. I want a one-bedroom or two-bedroom apartment, but god, it's hard to get them.”

Both Steve and John have experienced their share of mental health concerns. Steve no longer attends therapy – his therapist felt he was doing well enough to “graduate.” While John is looking forward to leaving McEwan House, he's aware that being on his own may be difficult, and he has a plan to deal with that. “I need to make sure that I don't get lonely if I do move out because that will be my depression, because I deal with depression a lot,” he says. “So what I'll do is I'll keep busy, I'll make sure I keep going to my [Alcoholics Anonymous and Cocaine Anonymous] meetings because meetings really centre me.”

Mental health and cognitive problems are a common aspect of living with HIV/AIDS, whether they are a direct result of the illness or not. The relationship between HIV/AIDS and mental illness is unclear, but generally, people with chronic illnesses experience higher rates of depression than those without.

Cognitive impairments are also an issue. According to Dr. Sean Rourke, a clinical psychologist and director of research for Mental Health Services at St. Michael's Hospital in Toronto, “cognitive complications of HIV happen in 30 to 50 percent of people living with HIV. What is most common is a neuro-behavioural disorder called Minor Cognitive Motor Disorder. It happens in about 20 to 25 percent of people with HIV, where there is clear documented evidence of cognitive compromise that affects daily functioning, such as work, or short-term memory.”

Whether or not there is a causal relationship, it is apparent that when someone is experiencing a mental health problem or cognitive impairment and has HIV/AIDS, the effects of each are compounded. Unfortunately, people living with HIV/AIDS often find that taking care of their own mental health becomes secondary to managing HIV, which in itself is a complex task. Often, health care providers and patients see depression and other mental health problems as the inevitable result of their HIV status.

According to AIDSmeds.com, an organization dedicated to providing people living with HIV the information they need to make empowered treatment decisions, “When a major source of stress is present, such as HIV-related problems, you may tend to accept depression as inevitable, understandable and unchangeable, and therefore inappropriate for medication-oriented treatment.” But as treatments for HIV/AIDS have improved over the last decade, and people are living longer, there is an urgent need to ensure that the mental health of people living with HIV/AIDS is not overlooked.

The desire to meet that need is what led Dr. Rourke to become involved in the Adding Life to Years project, a partnership of St. Michael's Hospital, the Ontario AIDS Network

and the Ontario Ministry of Health and Long-Term Care AIDS Bureau. The purpose of the project is to encourage and support community-based AIDS service organizations (ASOs) to address the mental health needs of their constituency. By developing tools, training and resources, as well as forging links to other community organizations, Adding Life to Years can help ASOs improve their level of “mental health literacy,” as Rourke refers to it, and their comfort level in addressing these challenges. He insists that the mental health and HIV/AIDS communities need to learn each other’s language and work together to develop programs that best address the unique challenges posed by living with both HIV/AIDS and mental illness.

“We need to break down the professional barriers,” Rourke states. “Think of the strength if all these groups came together.”

Funded by Health Canada through the National HIV/AIDS Capacity Building Fund, the Adding Life to Years project tapped into the existing network of ASOs to determine both the needs and capacity of the AIDS community to deal with mental health concerns. The researchers held focus groups of people living with HIV/AIDS and conducted surveys of ASO staff to determine where the gaps are in mental health care, and how they could be bridged. After the training and tools have been delivered, the role of researchers such as Rourke will be to gather evidence that the programs developed by the community are working for people living with mental illness and HIV/AIDS. “There is a good case to be made [for community mental health programs], and that’s where the researchers come in,” he asserts.

The project’s original partners are now collaborating with the national office of the Canadian Mental Health Association in a continuing effort to develop better mental health care for people with HIV/AIDS. One program that took place in Peterborough in 2003 provides a model of how two organizations can work together. The local CMHA branch partnered with the Peterborough AIDS Resource Network (PARN) to deliver a series of workshops specifically geared to the needs of PARN’s clients who had identified that they were experiencing symptoms of mental illness, particularly depression. The workshops began with a session on causes and symptoms, and concluded with a session on developing an individualized plan based on the techniques and resources they provided.

The success of the program was evident, according to Joni White, the Health Promotion Education Specialist at CMHA, Peterborough. “The participants picked up knowledge, coping strategies, a personal plan and validity for the feelings they were experiencing,” says White. “They may have felt that it was related to their HIV status, not necessarily a separate issue, but it validates what they have been feeling.”

As far as Nason is concerned, collaboration between the mental health and the HIV/AIDS communities cannot come too soon. The particular needs of people experiencing both

HIV/AIDS and mental illness are both unique and difficult. “There are huge barriers and huge challenges.” People with HIV/AIDS and mental illness are vulnerable, Nason notes. “The physical and emotional vulnerability is just phenomenal. You need staff that understand both [HIV and mental illness].”

Programs such as McEwan House and initiatives like the Adding Life to Years project are a good start. “There has been a slight improvement,” says Nason. “People are less afraid of HIV/AIDS than they used to be, and people understand mental illness better than they used to. Doors are opening.”

But of course, there is still a long way to go. Anyone who has a mental illness or HIV/AIDS will tell you that the battle against stigma is one of the most difficult. According to John, people “have a category of where you belong if you’re HIV-positive, and a category you belong in if you have AIDS: ‘If you’re HIV-positive you’re spreading it, and if you have AIDS,

The Adding Life to Years project can help AIDS service organizations to improve their level of “mental health literacy.” The mental health and HIV/AIDS communities need to learn each other’s language and work together to help the many people facing these two difficult health challenges.

you’re sick and you’re going to die...You don’t even deserve to be part of society anymore, so just stay in your corner.”

Jim Nason echoes John’s words. “One of the overriding issues that all the folks continue to face is stigma and isolation. People are very isolated. For people with mental health challenges, their families are burned out, or ashamed – and that’s compounded with HIV/AIDS.”

That was also White’s experience when she developed the workshops in Peterborough. “Families have had their limits pushed and may not want to be involved. With both mental health and HIV/AIDS, families sometimes develop distance and so the support network isn’t as good as it could be.”

For Dr. Sean Rourke, these challenges are what afford such a tremendous opportunity to make a difference in people’s lives. “This is a very unique social experiment that could lead to social revolution.”

For more information about McEwan Housing and Support Services, visit [www.loftcs.org](http://www.loftcs.org) or call 416-929-6228. For information about the Adding Life to Years project, contact Sean Rourke at [sean.rourke@utoronto.ca](mailto:sean.rourke@utoronto.ca) or 416-864-6060, ext. 6482.

# CALENDAR

## October 4-6, 2004

Making Gains in Mental Health and Addictions: Knowledge, Integration, Action. 2nd Annual Making Gains Conference. Toronto Hilton Hotel, Toronto, Ontario. For more information: 705-454-8107, fax 705-454-9792, [www.makinggains.ca](http://www.makinggains.ca).

## October 4-10, 2004

Mental Illness Awareness Week: Face Mental Illness. A national public awareness campaign organized by the Canadian Alliance on Mental Illness and Mental Health. For more information: [www.miaaw.ca](http://www.miaaw.ca).

## October 17-18, 2004

Psychiatrists in Blue: Things That Work. 3rd Annual Conference of the Canadian National Committee for Police/Mental Health Liaison. Hamilton, Ontario. For more information: 905-972-8118, [www.pmhl.ca](http://www.pmhl.ca).

## October 27, 2004

Mental Health in the City: Urban Innovations. George Brown College, Toronto, Ontario. For more information: [www.gbrownc.on.ca/mentalhealthinthecity](http://www.gbrownc.on.ca/mentalhealthinthecity).

## November 3-4, 2004

Building Links for Better Mental Health. Conference organized by the Ontario Health Coalition and the Ontario Public Service Employees Union. Toronto Courtyard Marriott Hotel, Toronto, Ontario. For more information: 416-443-8888, [www.opseu.org](http://www.opseu.org).

## November 25-27, 2004

Family Medicine Forum 2004. Joint conference of the College of Family Physicians of Canada and the Ontario College of Family Physicians. Sheraton Centre, Toronto, Ontario. For more information: [www.cfpc.ca](http://www.cfpc.ca).

## December 6-7, 2004

2nd International Conference on Spirituality and Mental Health. Organized by the Ontario Multifaith Council on Spiritual and Religious Care and the Department of Psychiatry of the University of Ottawa. Ottawa, Ontario. For more information: [clefebvr@rohcg.on.ca](mailto:clefebvr@rohcg.on.ca).

## February 3-4, 2005

CMHA BC Division's 3rd Annual Bottom Line Conference on Depression, Anxiety and Addictions in the Workplace. Vancouver Conference and Exhibition Centre, Vancouver, BC. For more information: [www.bottomlineconference.ca](http://www.bottomlineconference.ca).

## Leave a Legacy for Mental Health

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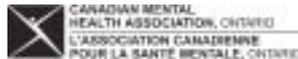
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To make a planned gift to the Canadian Mental Health Association, Ontario, please contact Mike McClintock at 416-977-5580 ext. 4159.



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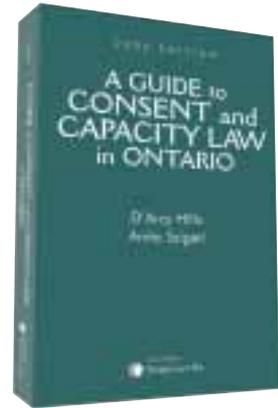
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