Toronto Central LHIN

# SUMMARY OF RESULTS FROM CONSULTATIONS ON PROVINCIAL THEMES FOR MENTAL HEALTH AND ADDICTIONS

Toronto Central LHIN

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Ontario
Local Health Integration Network

**Table of Contents**

**Background** ... 3
**Process** ... 3
*Health service providers' consultations* ... 3
*MHA consumers/ survivors' consultations* ... 3
*MHA families' consultations* ... 4
**THEME 1: SYSTEM DESIGN** ... 5
*Health Services Providers* ... 5
*Consumers/ Survivors* ... 6
*Families* ... 9
**THEME 2: HEALTHY COMMUNITIES** ... 10
*Health Services Providers* ... 10
*Consumers/ Survivors* ... 11
*Families* ... 14
**THEME 3: CONSUMER PARTNERSHIPS** ... 15
*Health Services Providers* ... 15
*Consumers/ Survivors* ... 16
*Families* ... 18
**THEME 4: BUILDING CAPACITY AND COMPETENCY** ... 19
*Health Services Providers* ... 19
*Consumers/ Survivors* ... 20
*Families* ... 23
**THEME 5: EARLY IDENTIFICATION AND INTERVENTION** ... 24
*Health Services Providers* ... 24
*Consumers/survivors* ... 25
*Families* ... 28

## Background

To support the Ministry of Health and Long Term Care's (Ministry) prioritization of mental health and addictions (MHA), a Minister's Advisory Group on Mental Health and Addictions was established to help lay the foundation for a 10-year strategy. The Ministry has requested that all Local Health Integration Networks (LHINs) undertake consultation on their behalf in order to get broad stakeholder input on the delivery of mental health & addiction services.

The findings in this summary report include feedback received from MHA health service providers, consumer/survivors and families. This report is formatted under provincial theme headings and the results are separated according to the group consulted in order to ensure accurate representation of each group's feedback.

## Process

*Health service providers' consultations*

Community stakeholders in the Toronto Central LHIN have provided answers to similar questions about the MHA system in the past through previous engagement initiatives. In order to honour that previous input, this information was leveraged for this consultation process. These previous initiatives include:

- Community consultations for the first Integrated Health Service Plan (IHSP);
- The Community Annual Planning Submission (CAPS) narratives (2008);
- Several recent reports.

The findings from these initiatives were presented through an electronic survey where health service providers were asked to provide feedback based on their experiences. The survey was sent to all LHIN-funded health service providers of mental health and addiction services and the 18 community health centres. In total, 27 responses were received. The results provided in the next section were also reviewed and vetted by the Toronto Central LHIN Mental Health and Addictions Steering Committee.

*MHA consumers/ survivors' consultations*

A MHA community engagement working group was established, comprised of consumer/survivors who volunteered their time to assist the Toronto Central LHIN in developing an approach that would help inform the Ministry in a meaningful and respectful way that was inclusive of many diverse population groups throughout the LHIN.

In order to connect with consumers, peer led focus groups facilitated by people with lived experience were held in targeted MHA organizations in Toronto. Peer Support Workers and volunteers attended a facilitator training workshop at the Toronto Central LHIN to enhance their facilitation skills and to provide a foundation to take a more active role in community engagement in the future.

Focus group questions were developed in collaboration with selected local health service providers, with input and direction provided by the working groups. These questions were piloted

in three different communities and refined in order to stimulate meaningful dialogue and garner responses from this hard-to reach community. Based on feedback from the initial pilot focus groups, it was determined that the initial questions were too high level and system based. It was decided that the questions would be further adapted to reflect lived experience. To further promote dialogue and meaningful discussion, "real life" examples were provided to the facilitators to help initiate discussion.

*MHA families' consultations*

A MHA community engagement working group was also established for families of people with MHA issues. A parallel engagement process was agreed upon and adopted by this group in order to connect with other families throughout Toronto. The facilitator training was offered to volunteers from the family community and focus groups were held targeted MHA organizations with family programs.

Both working groups identified a number of specific populations who have traditionally been either marginalized, or have not had the opportunity to represent their specific interests and unique needs.

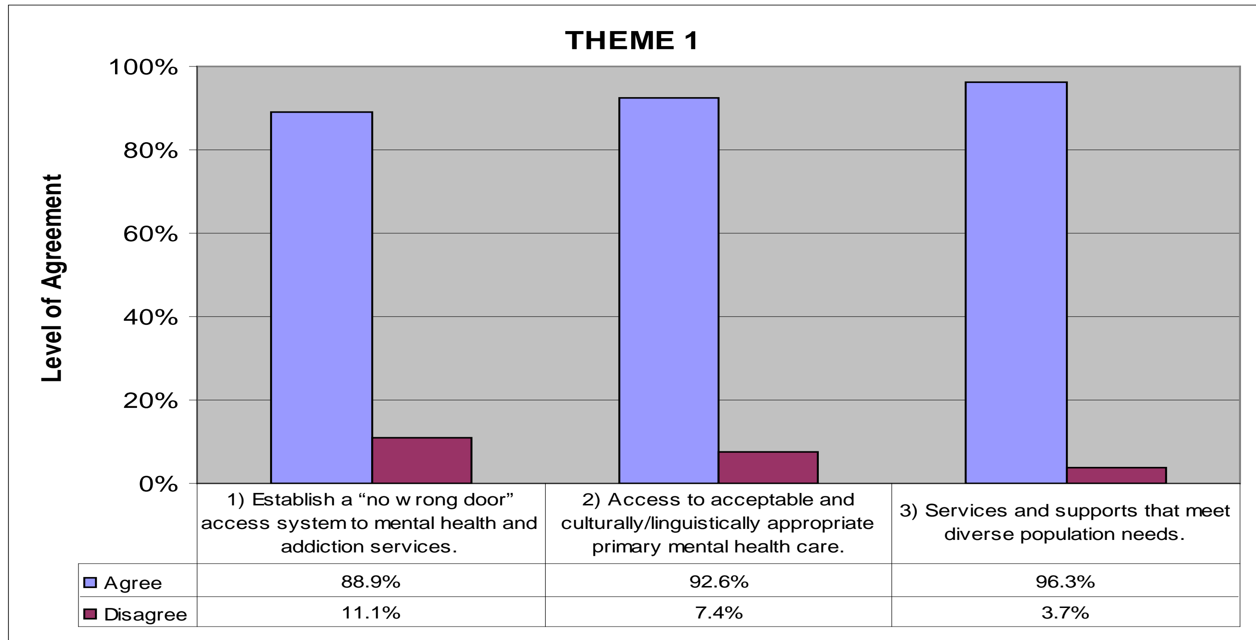
Included in this report is synthesized data from the HSP consultations and raw data from the consumers/survivors and families' consultations. Due to time limitations, the raw data could not be synthesized and is presented in bullet points, however, the consumers/survivors and families working groups will submit an analysed report to the Ministry later this month.

## THEME 1: SYSTEM DESIGN

*Health Services Providers*

Health service providers were asked to provide feedback on the following two questions:

**A. From a client perspective, what are the "top three" things that would improve access to and connectivity of services as to allow people to better move through the system?**




**B. What changes need to be made to the current system to improve capacity and better integrate services and supports?**

Below, the top 3 action items that should be undertaken to address the identified theme:

1. **Establish a "no wrong door" access system to mental health and addiction services**
    - Provide crisis service providers with adequate and timely access to other resources and services in order to resolve an immediate crisis and assist in diverting clients from emergency departments
    - Develop tools to minimize unnecessarily repetitive assessments
    - Preserve and enhance alternative points of entry to those for whom access is particularly difficult
2. **Access to acceptable and culturally/linguistically appropriate primary mental health care**
    - Develop and begin implementation of a plan to increase the mental health, addiction and primary care systems' capacity to provide collaborative care to service users and families.
    - Develop mechanisms to support partnerships and an improved access system (e.g. protocols, joint training, and common tools)
3. **Provide services and supports that meet population needs**
    - Develop and begin implementation of a plan to increase the use of evidence-based and promising practices within mental health and addiction programs by:

a. Serving individuals with significant and prolonged mental illness and/or addictions who have experienced homelessness or who have frequent involvement with the criminal justice system.
b. Optimizing the provision of client-centered counselling and support services for men, women and youth who are survivors of trauma.

- Work in partnership with settlement agencies to meet the needs of immigrants and refugees in housing, income, and employment.

*Consumers/ Survivors*

During the pilot sessions, consumers/survivors were asked to provide feedback on the following questions:

1. **What services are currently working the best?**
   - "I think about A-way as a model. It benefited me a huge amount. Being a courier means getting around in the city. I think I really built a lot of skills."
   - "I think a good psychiatrist or social worker knows their meds really well, and uses cognitive behaviour. It helps me do better things for myself."
2. **What can be done to make the current services better?**
3. **Are there services that we need that do not exist?**

*Theses questions were amended to include and reflect lived experiences, with examples. The new questions and corresponding answers are provided below.*

1. **Can you think of a MHA service that has really helped you? How?**
   - CAMH works: groups; assessment; 3-week programs; treating the root of the problem; aftercare
   - St. Mike's treatment centre – 6-month resident programs; 24-hour crisis line
   - Peer support really helpful
   - Peer support better than counselling
   - Breakaway: Sheila's Place – drop-in centre (food, feel like home, relaxation)
   - AA – helps with addiction
   - Having spiritual treatment in the program – i.e. daily spiritual routine
   - Stand up comedy – helps for a women's trauma program
   - Music
   - Art therapy
   - Yonge street mission (spiritual)
   - Silent retreat
   - Motivational speaker
   - Giving positive energy
   - House Link provide stable base to be saved from endless round of homelessness
   - House Link gives a chance
   - House Link only one of it's kind has most top notch in programs
   - Access to medication
   - Less stress
   - Own space

- House Link- high quality
- Food program amazing
- Fund stress reduction course
- Wrap training – in the long run, very good
- Able to have pets V.I.P. provided with growth and friendship

2. **What do you think is missing or could be made better about the services you've used?**
   - ODSP – bring back food allowance
   - House Link – have more money for furniture
   - House Link – Better screening of new people, i.e. crack, etc., dual diagnosis
   - Quality of beds and size insufficient: not all celibate: option for double bed
   - Staff have more training – crisis intervention
   - Members need assertiveness
   - A safe housing
   - Food – no one should go hungry
   - Better food in shelter
   - Buy our own food
   - More free recreational programs
   - Affordable transportation
   - Dentist (medical) support
   - Services should be done in timely manner
   - Accountability in Health Care system
   - Peer support group
   - positive enforcement
   - more places like Sistering
   - drop in centre – counsellor
   - Support clients when they needed
   - 211 is great, except is not free and should be free
   - Stepping stone to work
   - Stable environment
   - Community with within a community – friendship vital
   - Allows non-resident members
3. **Are there services and supports that you have really needed that you couldn't get? Why not?**
4. **If such services don't exist, can you describe what they would be like?**
   - Needs to be more peer driven and client directed: client does not have choice of treatment - client needs to have more control
   - There needs to be more agency accountability – needs to be more counsellors and workers with lived experience rather than academically educated counsellors
   - Workers who lack lived experience would receive training that is based on realities of communities rather than from textbooks
   - Holistic support should be offered that include the social determinants of health such as safe and affordable housing, proper transitional housing
   - It is difficult to find services that help you to quit smoking
   - Assessment is long and tedious, and seems to be only for agency purpose
   - Services are often located in different neighbourhoods
   - Mental health issues and addictions need to be treated at the same time
   - There needs to be more transitional houses for women

- Need more access to alternative healing practices, i.e. rehabilitation, massage, nutritionist, etc. like Wellspring, where they offer free alternative healing services
- We need more detox centres
- There should be more services for youth – the focus should be on prevention – consider nurse outreach in schools that provide 'real' education to students on topics including sexual health, addiction, and mother/ child
- There needs to be more outreach workers and case managers that offer life skills teaching, life coaching, budgeting and young mother education

5. **In the example below, what kind of services and supports could help someone break out of the day-to-day struggle that is keeping them from contact with the outside world?**
    a. *"A person who has not been doing well decides they need to do something to pick themselves back up again. They haven't been eating or sleeping much, avoiding friends and activities they usually enjoy, and pretty much keeping to themselves in their apartment. The person has also been pretty busy keeping voices in their head under control (which they find much harder to do when also dealing with neighbours, family, friends and even strangers on the street)."*
6. **Do you think it would be best for the person to get everything they need in one place, or are there advantages to plugging in to a number of places, each of which offer help with a different part of what's wrong?**

Other answers resulting from discussion but not categorized under questions: System Design

- Support of state program – 2 days top – addiction
- 1 or 2 nights of support, proper meals, teach how to mediate/relax
- Learn special skills – aftercare; aftercare/detox program in Toronto
- 21 days and 28 days doesn't work; longer than 28 days to clear addiction
- Like prison/supportive lounge for addiction
- Methadone works/need works to stop craving
- Personal desire to quit
- Monitor counsellor – record meetings with clients
- Better communication – counsellor/clients
- A simplified system after recovery
- One stop for – employment, I.D., housing, aftercare, education, etc.
- Transitional housing
- Police present to stop using
- Police need to be more educated (MHA)
- Too many woman drop in centres but not enough for men
- Support at younger age
- Early intervention works
- Trustee services – to pay rent, etc.

*Families*

During the pilot sessions, families were asked to provide feedback on the following questions:

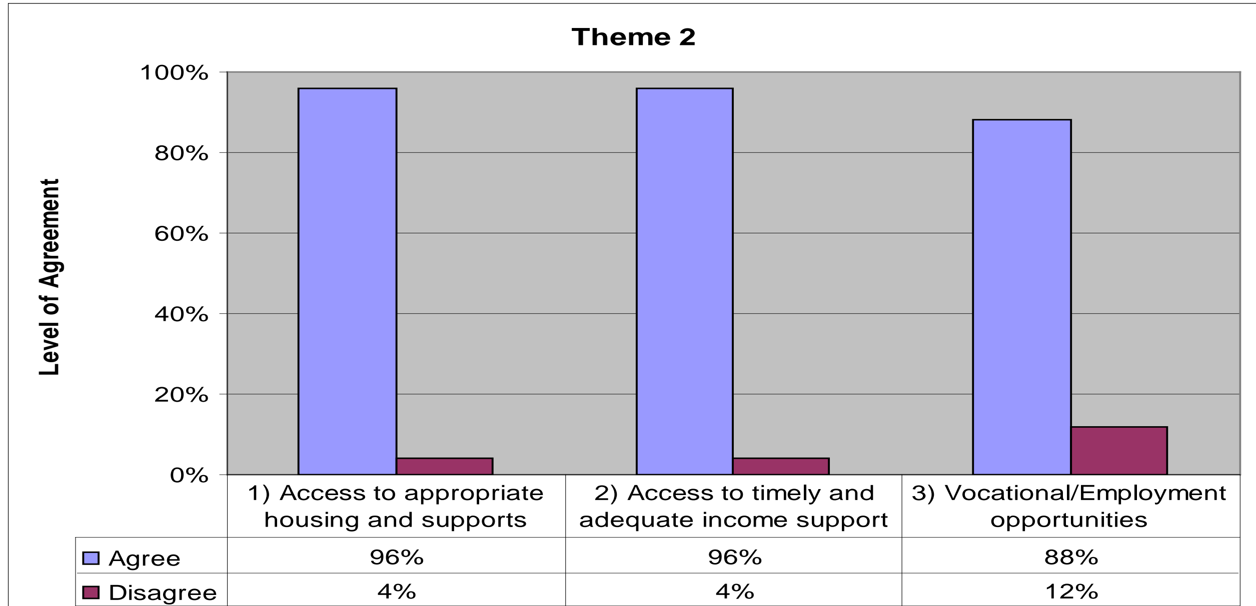
1. **Would families being recognized as an integral part in all aspects of the system, along with consumers, service providers, and the government, help make the system better***?*
   - Education for families- should be emphasized as part of the treatment plan
   - Health and wellness oriented programs
   - Families should be included in decision making
   - Family members should be interviewed early on regarding their knowledge of the situation- may need to advocate on behalf of someone who may not be well enough to make decision that are beneficial to their well being
2. **How do we stop family from being excluded from the treatment plan?**
   - Some mental health professionals may interpret the Mental Health Act to block the family, so further education for providers is needed here.
3. **What is needed in the system to help families and consumers?**
   - Family education
   - Individual education- starting to teach about mental health at a young age
   - Services that are appropriate for ethnic communities
   - Family support as the family has to recover as well as the client

## THEME 2: HEALTHY COMMUNITIES

*Health Services Providers*

Health service providers were asked to provide feedback on the following two questions:

**A. What do you think are the "top three" most important social determinants of health?**




**B. What change would be necessary to achieve improved outcomes in these three areas?**

1. **Access to appropriate housing and supports**
   - Provide more access to residential care options for clients who require 24 hour support.
   - Provide access to supportive housing for clients with concurrent disorders using harm reduction principles.
   - Develop a housing strategy based on client empowerment and choice and provide rent supplements to support these choices.

   Two other re-occurring "action items" under this theme included:
     - Expand community-based mental health and addiction support services *(suggested by 4 respondents)*
     - Enhance case management services in the community *(suggested by 3 respondents)*
2. **Access to timely and adequate income support**
   - Ensure rent allowances/supplements support an appropriate standard of living
   - Support nutritional allowances/supplements.
   - Further develop service hubs where access to identification documents, health care & income supports can be streamlined & accelerated.
3. **Vocational/employment opportunities**
   - Improve transitional benefit opportunities to allow people living with mental health or addictions to pursue gainful employment without fear of compromising access to income support or medication benefits.

- Provide effective and efficient delivery of case management services to support and meet clients' vocational goals.
- Continued development, implementation & evaluation of return to work initiatives & expansion of peer support initiatives.

*Consumers/ Survivors*

During the pilot sessions, consumers/survivors were asked to provide feedback on the following questions:

1. **What has helped to contribute to your quality of life?**
   - "Everybody needs a home, job and a friend, as the saying goes."
2. **What services have contributed most to your overall health?**
   - "Consumer survivor businesses make a huge contribution to quality of life. You can be having a really bad day, but you are with other survivors, and that's the biggest thing; that common ground in understanding."
   - "A-way and my own apartment, that plus exercise and meds, and a good psychiatrist, those have all been really good."
   - Information at CAMH
   - Health providers at local health clinic
   - Aftercare
   - Narcotics Anonymous
   - Speaking engagement
   - Seeing a doctor regularly
   - Good communication with doctor
   - Toronto Western Hospital – MHA program
   - Peer support
   - Registered nurse from local health clinic
   - Stability provided by Wellspring
   - Good support health care team
   - Toronto East General – 21 day treatment cycle and aftercare program
3. **What do you need to improve your quality of life and health?**
   - "Everybody needs a secure source of income. ODSP is a huge source of stress with all the clawbacks. Sure you can get your hundred dollars, but all the aggro around the paperwork, you feel penalized to work. Your quality of life is not being improved when with all the clawbacks you're making two dollars a day or it's even costing you to work. You should be funded and have a secure income until you cross the poverty line, funded up to that point. This would remove all the harassment and the worry."
   - "When you are in hospital back in the 60s they put you into sheltered workshops and I got to say that was important for things to change for me. You need work but not something that's too stressful. They sure don't pay very much money though."
   - "Substandard housing is a huge problem for health. When you stick everybody with problems into the same housing, they're all kinds of drugs and security issues. They shouldn't have all one kind of people in the same place, it's ghettoizing."
   - "Physical and mental health are coordinated, they have to go in a package."

- “Some of the food at food banks, they are like two months expired, that affects your health and your self-esteem. Nutrient deprivation is not healthy.”
- “It's all connected, if you need stuff for your mental health and don't get it, or for your physical health and don't get, it's like dominoes, this leads to that.”
- Income
- Decent job
- Stable healthcare
- Increase ODSP
- Agency accountability
- Pay for volunteer workers (peer support)
- Free education
- Resume workshops and job training
- Salary raises
- Increased screening of counsellors – more careful hiring process
- Training full time workers on the role of peer support workers
- Transitional housing
- One stop care support (employment, housing, education, etc.)
- Access to full time work instead of part time work

*Theses questions were amended to include and reflect lived experiences, with examples. The new questions and corresponding answers are provided below.*

1. **What does quality of life mean to you?**
    - To learn – specific to the person
    - More funding for education
    - Private funding for programs comes from fund raising
    - Not enough done to help House Link people to meet and mix
    - Being identified as AC/S
    - Has capabilities
    - A network of support outside of House Link
    - People who are seriously suffering need to outreach to others
    - Suffering – appear non-friendly
    - People interface with other members to encourage
    - Not coercive
    - Staff don’t necessarily know, as well as members, what actually works
    - Staff need more training
    - C/S training staff
    - Recovery means staff has to step back
2. **What are the key ingredients which make up your sense of the quality of your life?**
    - Place to go and feel safe, i.e. shared accommodation – Gerstein Centre other than your apartment or building, i.e. crisis – drug situation
    - More money
    - Less supervision from OSDP (OW)
    - Stop their punitive attitude
    - Get more political

- C/S be prepared to represent community
- House Link people don't have access to Psychiatrists or therapist
- Upgrade staff on mental health issues
- Quality pretty good now\
- Getting older – have more needs
- Expenses rising – income not rising, e.g. delisted medical – not covered by drug plan
- Nutritional needs – allowance
- Necessity – to go to food banks – without adequate nutrition
- Proper nutrition
- Affordable housing and equality housing
- Spiritual connection
- Internet
- Education
- Peer support
- Connection with community
- Friends
- Ability to go out to do activities in treatment (i.e. go see a movie; get coffee)
- Require support from communities
- There is a willingness to change – need support to not give up when in treatment
- Need to feel safe

3. **Do you think you could get help with that from the mental health and addictions system?**
4. **How could mental health and addictions services change to help consumers with their health and quality of life?**
   - Trouble - access Gerstein Centre
   - Support workers sometimes
   - Favour the person causing trouble, i.e. people victimizing others
   - In crisis – take whoever is on call – not your worker (feel safer)
   - No crisis team in House Link
   - After hours service
   - Hire C/S to be peer support
   - Getting hospitalization is very difficult, i.e. Family doctor referred with advocate
   - Interview was refused
   - If you sound incoherent, won't let you in
   - Building bridges to other communities
   - C/S needs money to go as NON
   - C/S – access community – activities, not a C/S thing
   - Feel you're in a ghetto
   - Meet people as peers in the community
   - Some need to protect their feelings from others as they recover, meet and interface with other communities
   - Learn how to trust
5. **Are there other services, outside of mental health and addictions that are important in you being healthy**?
6. **In the situation described below. what do you think he would need in his life to feel like it was back on track and worthwhile?**

a. *"A young man and his family immigrated to Canada from a war-torn country several years ago. He had thought and mood problems before they left (which he had always kept secret), but they became much worse with being in a really different, still unfamiliar world. His struggles to keep upsetting thoughts and feelings to himself became harder and harder, and eventually he leaves his family and ends up living on the street. He wants to be happy and feel useful and connected again, but in this new place and with memories fading of ever feeling that way, he's not sure how he got here and what kind of life to work towards."*

*Families*

During the pilot sessions, families were asked to provide feedback on the following question:

**1. What can be done to reduce stigma in the community?**

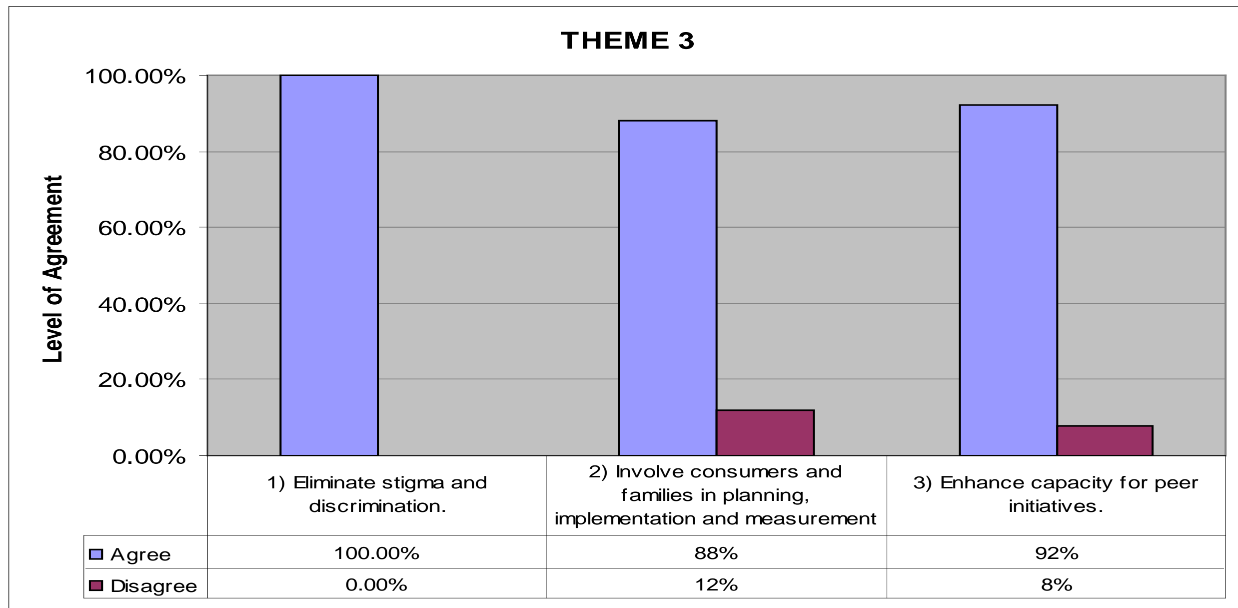
- Compulsory education for children should be mandated
- Use of media to empower people to talk about it more openly
- Normalize the illness. It is a long process to be considered as "normal" as something like homosexuality or cancer.

## THEME 3: CONSUMER PARTNERSHIPS

*Health Services Providers*

Health service providers were asked to provide feedback on the following two questions:

**A. What are the "top three" most important things that we need to do to facilitate consumer partnerships, peer support and mutual aid?**




**B. How do we create the necessary conditions for equal partnership and involvement?**

1. **Eliminate stigma and discrimination**
   - Collaboration with mental health and addiction system stakeholders, other LHINs, the MOHLTC, the Ministry of Health Promotion, and the provincial government to advocate for, support and facilitate the development of a national systematic and long-term campaign to combat stigma and discrimination.
   - Increase visible consumer/survivor participation in variety of roles.
2. **Involve consumers and families in planning, implementation and measurement for outcomes achieved**
   - Use consumer and family input to inform development of indicators for system performance.
   - Establish Service User and Family groups which will:
     - Develop a plan to enhance the peer support capacity within the Toronto Central LHIN's MHA system.
     - Develop guidelines and strategies to enhance involvement in all aspects of planning, implementation and evaluation of changes to the MHA system.
3. **Enhance capacity for peer initiatives**
   - Develop guidelines for development and implementation of peer support roles.
   - Support ongoing professional development and coaching for employers.

*Consumers/ Survivors*

During the pilot sessions, consumers/survivors were asked to provide feedback on the following questions:

1. **How important is peer support in the recovery process?**
   - "Peer support is huge. And I think of consumer survivor organizations as places of employment are crucial. Normal people get peer support at their jobs. We need more places that are supportive workplaces where mental health stuff is part of the scene. Because even if you have peer support and you're in a bad job, peer support can't help with that, if they don't understand about mental health."
   - "A lot of the peer support workers now and working in the system are just so thankful to be let into their little circle, the workers that is. It is total tokenism, and peer support workers are just so grateful for being included."
   - "For peer support to mean anything, they would have to start with valuing the opinion of consumer survivors in the 1st place."
   - "Workers come at you like a 'know it all' already, but I feel like I have greater knowledge of the workers problems than she does. Every person has strengths and weaknesses, workers or peers."
   - Very important
   - Not sensitive to C/S needs
   - More C/S leadership
   - Peer support inspirational
   - Gives them hope
   - More meaning
   - More contribution
   - Peer support – more than a token
   - Looked down on
   - Set goals for C/S in "Decision Making Management".
   - Mental health should be better resources
   - Peer support workers are essential
2. **Should you have a voice in developing the services you use?**
   - "Consumer survivors should be involved at the top, as well as the ground-level, at every level."
   - "In all consumer survivor initiatives, you still have to be able to do the job, and have lived experience that is constructive. But it should be us who determines who is a peer support worker or not. We should produce the candidates for being supports, they should come to peers to get candidates."
   - "I don't think we should confine the role of consumer survivors in the system to peer support workers. Survivors should be involved wherever they fit in, judging services or directing research."
   - Consumers should absolutely play a role in developing and improving the services that they use
   - Consumers can provide their personal and lived experiences to help develop a plan
   - Consumers should stand up together to voice their needs
   - Services that are peer driven need to receive more funding and support

- Consumers may not speak out about the services they access as they are worried about being kicked out of the service if they speak up
- In House Link - surveyed about Ethnic Origin
- Social interests – very white, except aboriginal – LIFT
- GPPs – House Link could, but don't mix and access – to help with each others problems
- More access to leadership training

3. **How can we be part of this process?**
   - "There must be a way to make developing insight into other people and of the world part of the education system. That should be a pre-requisite to work in mental health. Workers need insight, understanding and knowledge of the world to help people."
   - "Peer support workers should be trained by other consumer survivors."
   - "There needs to be education on both sides, so the survivors can take any position in the system. People would freak out if somebody said that a LGBT person can only work at the 519. I think there is more stigma and discrimination that explains how survivors are treated. You would never say something like that to any other marginalized group."
   - Need to provide proper training for peer support workers
   - Need understanding and compassion form peer support workers

*Theses questions were amended to include and reflect lived experiences, with examples. The new questions and corresponding answers are provided below.*

Participants were asked if they had ever been involved in any policy-oriented or governance meeting, such as a community consultation, or a board meeting. If this was the case, the following questions were posed:

1. **What was that like for you? Did you think the consumer point of view or voice was represented there?**
2. **What do you think you or other consumers might need to participate more fully in decision-making in such meetings?**
   - Aftercare peer support program
   - Accountability staff
   - More data collecting from consumers
   - Transgender shelter
   - Need more peer support services
   - More training to be peer support
   - Share experience with peer, someone who has the experience and not from the book.
   - Respected from friends (important).
   - Look at the peer as a mentor (supportive person).
3. **Do you think consumers should be involved in planning services? What about consumers delivering services?**
   - Hire consumer/survivors on phone to go to consumer/survivors home for crisis intervention, e.g. NZ – crisis interview – move in to help
   - OHIO – CSRUN Agencies – GYM/Advice and support housing
   - U.S. – Peer support well funded
   - Government provide money for our success (i.e. MOH).

4. **What does the phrase "peer support" mean to you? Have you had any experience with a peer support worker or peer-support services? If so, what about that connection has made a difference to you?**
5. **How would you advise the following person?**
   a. *"A woman who has been connected to the mental health system for many years becomes aware that one of the community agencies she uses has begun to offer services delivered by "peers". She understands this to mean that the workers are or have been users of mental health and addictions services. She is uncertain what she can expect from, and ask from, this worker. Is it okay to ask what king of problems they've had and what kind of training they've taken? And what are they going to need to know about her –her diagnosis? Family, medical and employment history? What's going to make this different from all the worker-client relationships she has had up to now?"*
6. **What do you think you would have to offer the advisory group described below? What do you think you would need in order to provide it?**
   a. *"You have been asked to join an advisory group that is helping develop the future shape of services delivered by an agency. This group will have representatives from the agency staff, from the ministry of Health, and from the medical treatment team that coordinates each service user's care."*
7. **What might get in the way of you being a real participant in the meetings of this group?**

<u>Families</u>

During the pilot sessions, families were asked to provide feedback on the following questions:

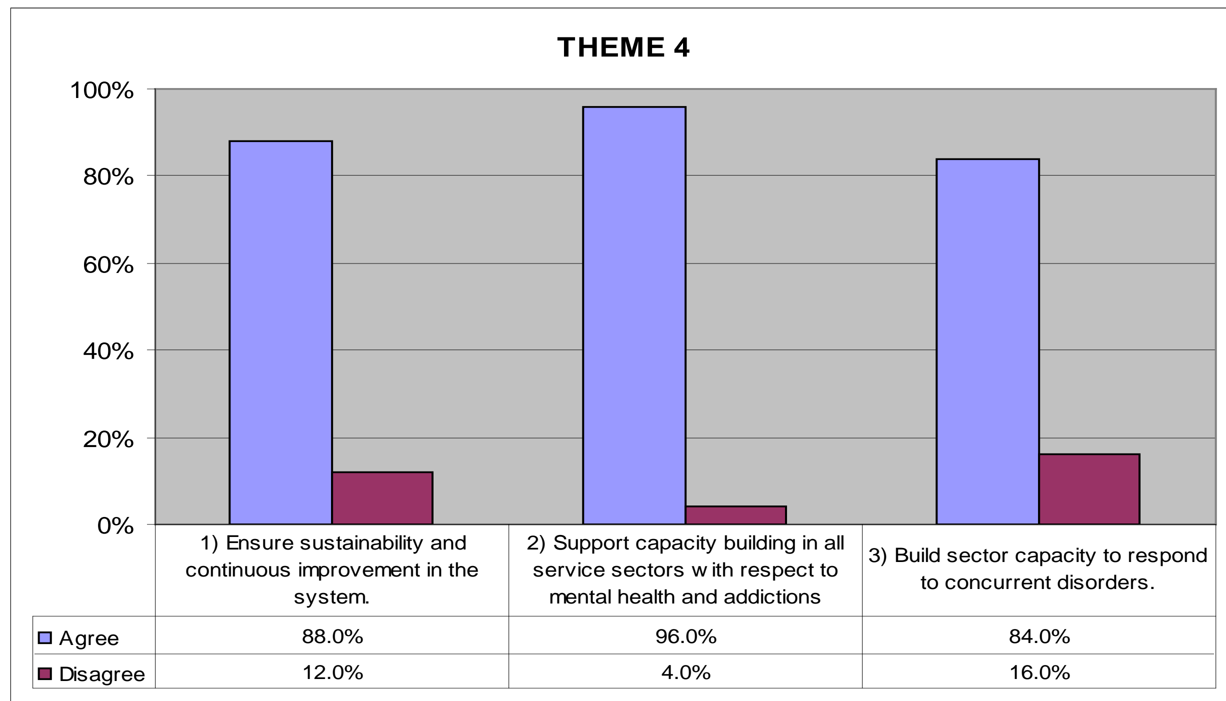
1. **How important is peer support in your recovery?**
   - Having someone share actual proven ways to cope is incredibly helpful and inspiring.
   - It helps with stigma.
   - It gives someone who is suffering a role model they can relate to.
2. **What do families need, in regards to programs or services?**
   - Someone to vent to.
   - A source to share information with other individuals or families (e.g. books, movies, groups, etc.).
   - A 12 step model similar to Alcoholics Anonymous would be beneficial.
   - A manual, telling families what they need in plain English, like a formula of sorts. There is a basis for recovery common to all cases. From there, this is tailored to individuals.
   - Individual therapy or joining an organization like SSO.
   - More trained family workers.
   - Family involvement and input needs to be respects and encouraged by health professionals.
   - Family input with the medical team needs to be validated (at the same time, the family needs to have some trust in the system, that it can help their loved one).
   - Collaboration between the family and the medical team must be emphasized and even mandated!

## THEME 4: BUILDING CAPACITY AND COMPETENCY

*Health Services Providers*

Health service providers were asked to provide feedback on the following two questions:

**A. What are the three most important things that we need to do to achieve this goal?**




Another reoccurring theme identified:

- Enhanced capacity needs to be supported by a workforce that is adequately educated, trained, supervised and compensated.

**B. How do we create the necessary conditions to sustain quality delivery of MHA services over the long-term?**

**1. Ensure sustainability and continuous improvement of the system.**

- Support integration initiatives and opportunities that offer solutions to preventable EF visits and ALC issues among patients with complex needs. (E.g. initiatives that foster partnerships in high-support housing, increase the impact & capacity of psychogeriatric outreach teams, primary care and community-based support services & create sustainable community supports.
- Collaborate with the MOHLTC, the LHINs and other key stakeholders to develop a mental health and addictions labour market strategy that addresses skills, job requirements, compensation, and recruitment and retention issues, ensuring equitable compensation for like roles across the system. This strategy should include recruitment and retention of culturally and linguistically competent, clinically trained mental health professionals from identified target communities.

2. **Support capacity building in all service sectors with respect to mental health and addictions services for particularly complex populations.**
   - Transform training and care to a recovery orientation system, including short, medium and long-term strategies. This process should include a cross-national comparison of effective practices, a clear and consistent definition and operationalization, development of education/training to support this system, a broad definition of cultural competence, health equity, early identification and intervention among visible minority populations and youth, and enhancing service user and family involvement in all aspects of care.
   - Collaborate with stakeholders to develop a long-term education and training strategy that identifies key competencies and skills, approaches education and training needs in a systemic fashion, and expands the range of education to include broader health and social services workers.
3. **Ensure sustainability and continuous improvement of the system**
   - Develop a plan to enhance the capacity of service providers to meet the needs of people with concurrent disorders wherever they enter the system.
   - Address identified needs of aging clients with concurrent disorders, including housekeeping, nutritional & personal support & transportation.

*Consumers/ Survivors*

During the pilot sessions, consumers/survivors were asked to provide feedback on the following questions

1. **What do you think will help MHA workers to deliver better services?**
   - “The big problem is that this could lead to them starting to label everybody, and it's like with ADHD, once you're labelled that's it.”
   - “There are some things that support workers can't help with, like ODSP clawback.”
   - “I think it's really important to have rights advisors. They could help make sure you don't get bogged down in one bad relationship with a worker.”
   - “One of the biggest problems in helping professions especially mental health, is just an us and them attitude. They have this kind of professional empathy, but never see themselves as people in need too. I think there needs to be some development done there, like they'd never admit their own mental health challenges. It would be good since they're supposed to have been trained if they could develop some of that. I think it's a defence mechanism on their part that the only thing about us they focus on is our problems, so that you’re identified by your problem.”
   - “There should be reviews on the professionals by clients. There's no malpractice in mental health like there is in medicine. There's no set of standard capabilities.”
   - “I think one thing that's really wrong is that they'll tell you what your problem is.”
   - “I think it's really important that workers know the resources that can help you, like how to break down the crisis, like having some teaching skills, instead of saying things like “come back when you're problem slow down”. This plus the kind of false upbeat thing, which makes me feel belittled.”
   - “I have a girlfriend who has CP, and the people who are hired to help her are a lot more accountable. It's not just one worker and you're stuck with them.”

- "Many workers don't have even the most basic understanding of support. They are so uptight. They need to be more proactive."
- Education on lived experience should be provided by peers
- Credibility of workers increases when they have lived experience
- A good worker is empathetic, understanding and is willing to listen and help
- There needs to be a high level of transparency in the service agency, so that clients are aware of what's going on
- There should be more access to professional development for training of mental health and addictions workers
- Staff should be screened when hired to work in this field
- Staff need increased education around understanding people of diverse backgrounds

2. **What skills and attributes are necessary for MHA workers to connect with you?**
   - "I think education is really important in being a good worker. I have a really flighty social worker. Even students have been more informative. I don't think a lot of people are making informed choices if they're working with workers like I have. It pisses me off that we are supposed to be grateful for inadequate services."
   - "I wish I had had more workers who respected my autonomy and privacy. Being in the mental health system gets sensitive to this really early."
   - "I think there should be more social skills, in the workers. And there's no follow-up either. Sometimes we do an extreme cleanup in somebody's place, but then that's it. There needs to be more follow through, and more of that social aspect."
   - "I think getting to where you can take care of yourself is a good outcome."
   - "In my day, there seemed to be more courses and supervision. These days they don't seem to try to develop basic thinking skills. In my life when I look back at think about how I might do things differently that's one of the things that's very useful about Bono's ideas, is understanding different kinds of mistakes in thinking [long description of monorail and misfit mistakes]."
   - "I really hate how much condescension you have to put up with, like your stupid or five years old. Instead of that, they need a lot more compassion."
   - Common sense
   - Human quality
   - Real life experience
   - Open minded
   - Thinks outside the box
   - Compassionate
   - Not opposed to value system
   - Understanding of diversity
   - Non-violent communication
   - Free from judgment
   - Learns from clients
   - Admits mistakes
   - Approaches people with no-judgment
   - Provide money who are taking PEER Course so they could train others, E.G. Ladder
   - Relate well with staff to facilitate a real recovery
   - Learn to ask C/S. What are your ideas and their goals, what their needs are

- What can  do to help wit your goals
- Client centered – too often prescription
- Concentrating on petty things – i.e. polite correct language
- Monitoring people is not recovery
- Workers need to have personal experience and lived experience with MHA – formal education is less important
- There needs to be monitoring of counselling sessions with MHA workers for quality control – check to see how clients are doing
- The workers must be compassionate, understanding and open to suggestions
- Crisis Workers – must work with clients directly
- There should be sensitivity training offered to staff on a regular basis
- There should be the option to request a change of counsellors when a conflict happens

*Theses questions were amended to include and reflect lived experiences, with examples. The new questions and corresponding answers are provided below.*

1. **Today, or in the past, have there been workers who have really made a difference to you?**
    - Older person teaching new support worker their job, i.e. trade spots for a time
    - Some workers are naturals – with treating people with respect
    - Workers taking advantage, i.e. gave locker away to others
    - Can't see the follow through
    - Therapeutic to air your problems to someone
    - Workers forget golden rule – "Treat others as you would like to be treated", i.e. things stolen – worker replied, "why would anyone do that"?
2. **What was it about the services they provided or the way they helped you that really made a difference?**
    - Go out of their way sometimes
    - Rushing – think their on a tight schedule
    - Will give you space – provide your own structure
    - Sensitive – ODSP – glasses not paid – worker helper individual  by going out his way to help her get her glasses
    - Take him out for BD.
3. **Do you think that what was particularly helpful about that connection is something that can be found in other workers or services?**
4. **Do you think it's something that can be developed or taught? What is it that would need to be "passed on"? If so, how should it be taught, and be who and where?**
5. **In the following situation, what would you want to be on the menu?**

    *"You are living in a parallel universe, where things are exactly as they are here except for one key difference. Users of the mental health and addictions system get to select the qualities and skills they want in their workers, counsellors and Doctors – like choosing all the different ingredients to a perfect sandwich."*

*Families*

During the pilot sessions, families were asked to provide feedback on the following questions

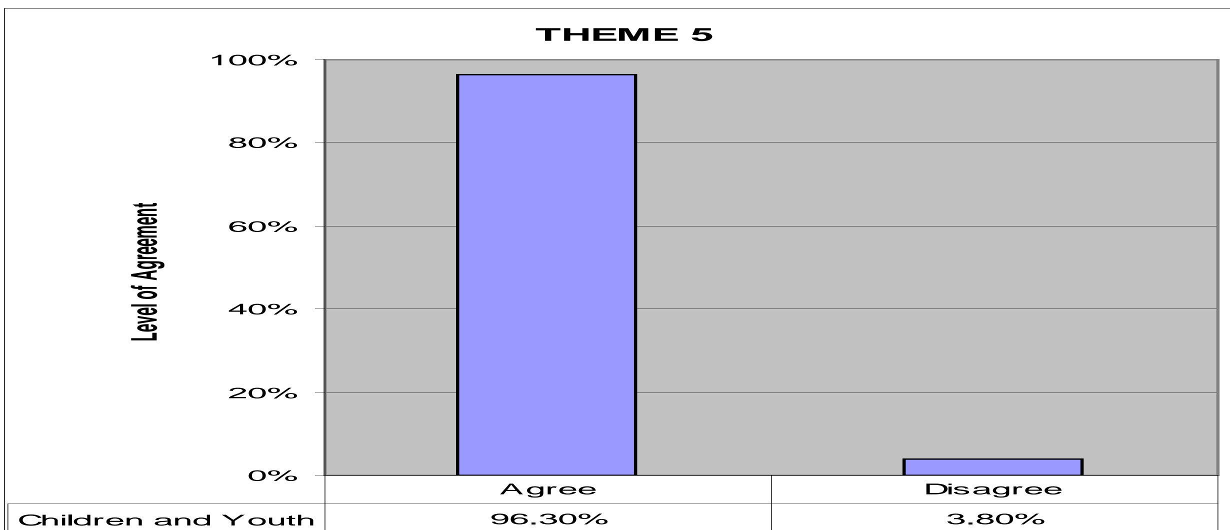
1. **What do you think will help MHA workers to deliver better services?**
    - Longer admissions for observations and ensure individual is stabilized before discharged.
    - Continuous care to stop the revolving door (the illness just doesn't end; support is needed for any problems that may arise).
    - While in the hospital, patients need therapy.
    - CBT (Cognitive Behavioural Training): the criteria may eliminate a lot of individuals but this type of therapy can help a delusional person rationalize with themselves.
    - Nurses need to be trained in CBT or similar talk therapy techniques, because sometimes patients just need to talk it out, or need someone to be positive and reinforcing in order to change the situation or need to redirect their thoughts.
    - CBT gives individuals the tools to cope and deal with their illness better on their own
    - Psychosocial education.
    - Ongoing psychosocial supports- outside of the hospital setting.
    - Incentives to encourage wellness initiatives (e.g. clothing allowance, TTC passes and Clubhouses-Progress Place).
    - Volunteer/ employment opportunities for those who are well enough (e.g. meaningful job training, supportive employment).
    - Legislate employment for people with mental illnesses. For example, companies get an incentive, designate a % of the workforce to be people with a mental illness and/or ensure they can do the job- employer could get a bad taste if not and it would also be difficult for the individual with the illness to not succeed.

## THEME 5: EARLY IDENTIFICATION AND INTERVENTION

*Health Services Providers*

Health service providers were asked to provide feedback on the following two questions:

**A. Where and with whom can early identification and early intervention make the biggest impact?**




**B. Which initiatives below, associated to the CHILDREN AND YOUTH group, to address early intervention resonate with you?**

- Emphasizing a health promotion and anti-stigma approach around mental health issues and psychosis that involves both youths and families and includes non-English speaking communities.
- Education and linkage to primary care as often first point of contact.
- Supporting families on current parenting issues, psycho-education/early identification and dealing with generation gaps for immigrant populations.
- Increase support within school with trained school counsellors to provide counselling and early identification – including those with academic problems at school, learning disabilities, developmental disabilities, and those facing school bullying and discrimination; also important at "alternative schools" and ways of streaming students to those "alternative schools" with proven outcomes.
- Community hubs that include mental health services established in neighbourhoods particularly where high levels of disadvantaged populations live.
- A shared care model that keeps GPs and paediatricians involved throughout the person's care.

**C. What is the single biggest obstacle for achieving this goal and how do we address it?**
**Obstacle:** Poor transition from children to adult mental health services**.**
**Initiatives**:

- Increase the capacity of Nurse Practitioners.

- Encourage youth to lead and participate in mental health programs.
- Increase peer support systems across age ranges even with children.

<u>Consumers/survivors</u>

During the pilot sessions, consumers/survivors were asked to provide feedback on the following questions

1. **What services are effective in addressing a crisis situation?**
   - "Short stay crisis beds are real help like St. Mike's and Gerstein. Places where you can slow down and regroup and avoid hospitals."
   - "Non-medical places like Gerstein, a little more lax and inviting, that's more comfortable, that helps with crisis prevention."
   - "I have a good social worker and Dr. If I call him, they will call me back. I have easy access, they are accessible."
2. **What services and/or supports can be provided in order to prevent a crisis situation?**
   - "ACT doesn't work, that's for sure."
   - "We need integrated services, a system that reflects the quality of a holistic approach, that works with the whole person. Instead of this service over here and that service over there. There should be one central person to link it all up at least."
   - "There need to be services that strengthen friends and family, those are important for crisis. And places like Friend and Advocates."
   - "They should have walk-in clinics for mental health. They should have like a network of support, and have like available understanding social workers. It should be an accessible place, and early response like a mental health walk-in clinic where they are more empathic and supportive."
   - "There should be an advisory consumer survivor group, made up of survivors, to oversee these changes."

*Theses questions were amended to include and reflect lived experiences, with examples. The new questions and corresponding answers are provided below*

1. **When you have been having a really bad time, what has helped?**
   - Distress centre hotline
   - Gerstein Centre
   - Community relations officer are great for ongoing crisis and often give suggestions how to solve problems and deal with court
   - Homeless friends
   - John Howard Society
   - Someone to talk to (that is gender/ culture specific)
   - Pre-treatment
   - Good community supports: more prison support for MHA; life skills; self care; awareness;
   - Nurses should be in schools and small housing complexes in order to help people with prevention
   - Daily outreach workers
   - Harm reduction

- Useful staff in drop-in centre
- Peer support
- Smooth transition from detox to treatment and transitional housing (aftercare)
- Access to hostels if there is no housing available
- Provide anger management classes

2. **Do you have supports or services you turn to when you're in crisis?**
   - See GP/Psychotherapists (15 years)
   - House Link Support Workers not therapists – don't have mental health expertise
   - Doesn't have to be House Link worker
   - Have to stake responsibility
   - Need to build a network of support around us – need worker to help build
   - Do I want – alternative – PEER Support
   - Psychotherapy?
   - Need continual support at the time
3. **What have you found helpful in getting to the other side of a bad time?**
   - Bike ride with friend
   - Pet (dog)
   - Talk with someone you have a close relationship with
   - Go to see movie, or window shop (winners), eat
   - Cook dinner together
   - Be good to yourself
   - Lot of caring people out there are hidden
   - Visit friend who's in been hospital for ten years (family disowned her). Person dropped off new clothes.
4. **What could be improved or added to those services and supports? What should be gotten rid of that has been unhelpful**?
   - More money for C/S needs staff got and we didn't.
   - Get PEER support back
   - Less consultants
   - More C/S participation, i.e. facilitation
   - More analysis of what we offer – i.e. response to food program – Good
   - Response to other social recreation – poor
   - How many people go to what?
   - Results based on what's being done.
   - Scheduler – nights weekends – maybe though PEER
   - Don't want Christmas presents
   - Diverting money to PEER Support
   - More money into Peer Support
   - Rely less on expenses
   - Help surveys – from within
   - People who rather opt or supports get elsewhere
   - Relate to you as a human being
   - More self contained units
   - Shared is difficult at times – no privacy – having a friend

5. **In the situation described below, what are the advantages and disadvantages of these two ways of handling a bad time?**
    a. **Are there other ways?**
    b. **If you didn't have to choose between these two options, and could invent one, what would it be?**
    *"You've been feeling screwed up for a while, but things have started to get a lot worse. You've talked to a couple of friends on the phone about your worries and how you're doing, but you've gotten very different kinds of advice. One friend recommends you take yourself off to the hospital, talk to someone there, see about getting a bed or stronger meds, and talk to your shrink as soon as possible. Another friend advises you that the meds/hospital/shrink route is the worst thing you could do. The best thing you can do, this friend thinks, is wait this out until things settle down enough for you to connect back up with your friends and family, and get back to the 'okay' place you were in before things started to go wrong."*

**Early Intervention:**

- "I got my first psychiatrist when I was 12, at Sick Kids. But I just took off over and over."
- "As a parent now with that point of view, my daughter has to deal with a lot of stigma. I know she needed mental health help, but she'd rather be seen as having an attitude problem than having mental health problems. And there should be some consideration if a child doesn't want CAS involved. Because CAS just keeps producing fractured families without support. And all the leading suggestions from guidance counsellors, where schools have guidance counsellors are the first response. They treat the child as separate instead of listening to the parents more. It's stigmatizing for the family."
- "I grew up as a Crown Ward and had to see psychiatrists and social workers. And they are rotated like bad tires. I've never understood it, when you get assigned to someone, if they are still on staff why they need to transfer you to another worker. If they have another job or leaving that's one thing. But they seem to have their human resources management issues, and have to make sure to be breaking bonds if they're getting too close. I just think if you have formed a good connection and in the absence of a legitimate reason you shouldn't switch workers on the kid."
- "And then you turn 18, and it's bye-bye. I had two years of bad jobs and unemployment, and I had no one. There has to be recognition of the need for some kind of transition, and they needs to be a discussion about it with the youth."
- "These age range systems are messed up, they are constantly going by the ages and stages. People have their own patterns of development and their own phases."
- "Guidance counsellors as a first response are really bad news. They're all about how "she doesn't respect her teachers", so that it's all about deference instead of sensitivity to mental health issues."
- More outreach programs are needed
- Peer workers should have to be clean and sober from substances for a minimum of 6 months
- There should be more accountability workers that watch/ monitor client's behaviour
- There should be a specific worker that reviews the quality of services being provided
- Workers need to have more complete training
- Mental health police need to be educated – often are overly physical to clients

- Women require 24 hour staff that are female – need separate programs for men and women
- Need more experienced crisis workers
- Need to limit scented body products in the work environment and MHA service
- Need more drop-in centres and shelters
- Staff should be re-evaluated every 6 – 8 months
- There needs to be a 24-hour crisis lines
- There needs to be more connections and introductions made from clients to staff when turnover occurs or case managers/ counsellors change

*Families*

During the pilot sessions, families were asked to provide feedback on the following questions

1. **What can be improved/ added to crisis oriented services and supports that exist now?**
2. **As a family member, what supports are needed if you suspect someone has a mental illness***?*
   - How much training do paediatricians/ family physicians have in psychiatry?
   - Additional education: especially in insidious/ disorganized cases, the illness comes on slowly and the symptoms are very subtle- difficult to detect early if you don't know what you're looking for
   - School counsellors should also have proper training to deal with this issue, as should teachers
   - How do TeleHealth Ontario employees handle hearing psychiatric symptoms? There should be a psychiatric oriented telephone advice line for people who are confused or concerned