United Way
Peel Region

MAPPING THE MENTAL HEALTH SYSTEM IN PEEL REGION
Challenges and Opportunities

REPORT AND RECOMMENDATIONS

January 2014

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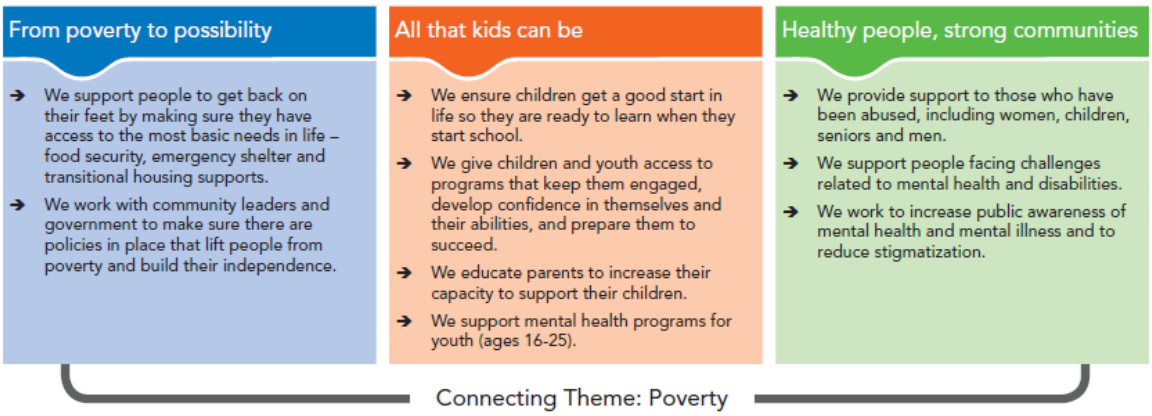
INTRODUCTION AND BACKGROUND

United Way of Peel Region and its partners have identified mental health service access and navigation as a key priority in improving the health and well-being of Peel residents. This priority must also be understood in the context of ethnocultural diversity in the Region. To this end, United Way developed a community-based research strategy to pursue a greater understanding of the mental health system, common barriers, promising practices, and opportunities for improvements.

Taylor Newberry Consulting (TNC) was contracted by United Way to carry out this research project. This report provides a detailed summary of the project findings. The report is organized according to several core service areas or sectors that comprise the mental health and social service system. Each section contains a description of the service area/sector, guided by the use of visual "system maps". Challenges, barriers, and gaps are discussed, followed by opportunities and recommendations for system improvements. The report begins with a background summary of the project, the goals of system integration, and the methodology used to gather the information.

UNITED WAY OF PEEL REGION'S INVESTMENT STRATEGY

In early 2013 United Way of Peel Region announced its new investment strategy.[1] The strategy recognizes and addresses the debilitating effects of poverty in Peel Region, by focusing on three areas: 1) *From poverty to possibility*; 2) *All that kids can be*; and 3) *Healthy people, strong communities*. Within each priority area, United Way seeks to create greater access to effective and responsive community supports and services. The key elements can be seen in the accompanying diagram.



A central component of the strategy is a focus on mental health and disabilities. United Way is committed to providing support to people who experience difficulties due to abuse, mental illness, and disability, while playing a leadership role in public education and destigmatization. Through strategic funding to local organizations, programs, and partnerships, United Way seeks to improve access to service and supports, and

[1] http://www.unitedwaypeel.org/news-a-events/media-centre/2013-media-releases

to increase well-being, social competence and community integration among people who experience mental health challenges.

The priority focus on mental health within the investment strategy has been prompted by an improved understanding of community need and evolving demographics. It is well-known that there are unacceptably long wait lists for mental health, addictions, and other social services in the region. Given the rate of diagnosable mental illness – about 1 in 5 – almost 260,000 Peel residents will be affected at some point in their lives. Another important characteristic of Peel Region is its cultural diversity. Over 20,000 immigrants settle in the region annually and almost 50% of Peel residents are newcomers. Overlaying these factors is a steady rise in income inequality and an increase in overall poverty. A recent report from Dr. David Hulchanski at the University of Toronto demonstrates that the percentage of residents with low or very low incomes (i.e., less than 40% of average individual income) has risen from 1.5% in 1980 to 45% in 2010. Middle income has fallen from 86% to 49% in the same period.[2]

United Way takes a social determinant of health perspective that views health and wellness as a product of multiple interrelated factors which impact individuals at multiple levels.[3] Individuals, families, communities, social and health systems, government, funders and others all have roles to play in promoting health and wellness. In this view, mental health is not reducible to an individual problem to be treated narrowly; rather it is a shared responsibility of communities to promote the conditions for collective well-being and to prevent isolation, despair, and illness. Improving a community's ability to best respond to the needs of residents requires a system-level perspective and a commitment to collective action.

OUR ASSUMPTIONS REGARDING MENTAL HEALTH AND MENTAL ILLNESS

It is important to clarify the distinction between mental health and mental illness. Mental health can be defined as:

> "…the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity."[4]

Mental health is concerned with health promotion and the prevention of illness, and is tied to multiple individual, physical, social, economic, and community level factors that affect our daily lives. Mental illness is more specifically in reference to impairments in thinking that lead to significant distress and daily problems in living. The severity of symptoms can range from mild to severe.

[2] For more information see http://neighbourhoodchange.ca/2013/05/18/peel-region/
[3] For example, see http://ontario.cmha.ca/mental-health/mental-health-and-well-being/social-determinants/
[4] Government of Canada (2006). *The Human Face of Mental Health and Mental Illness in Canada*. Ottawa, ON: Author.

Many mental health services are designed to specifically target individuals with severe mental illness, characterized by a minimum duration of symptoms that lead to clear disability in daily life, and consistent with diagnosable symptoms. While there are biological and heritable causes of mental illness, the influence of the environment, such as early childhood experiences, family dynamics, personal relationships, and a range of social and community stressors, plays a significant role.

The role of the environment is similarly crucial to the attainment of positive mental health. It is important to note that mental health is not merely the absence of mental illness. Rather, mental health refers to an experience of emotional wellness and happiness that follows from strong personal relationships, a sense of community connectedness, and resilience against stressful life events.

A holistic view of mental health and mental illness challenges organizations, policy makers, government and communities to look at mental health and wellness as a complex set of individual, physical, social, economic, and community based factors. The “mental health system” is therefore not limited to direct, clinical, treatment-focused health services. It extends much further to include a range of social and community base services that are equally interested in strengthening and promoting health, as opposed to merely treating problems that have already emerged.

MENTAL HEALTH AND ADDICTIONS SYSTEM INTEGRATION

United Way’s focus on mental health and addictions also comes at a time when community health systems are reorganizing to improve system integration and service coordination. Integration is a prominent concern in most contemporary policy frameworks and planning documents regarding mental health and addictions. It refers to structural and procedural changes in local service areas that will help programs, organizations, and systems operate together in a way that promotes (ease of) system navigation, service access and a continuity of supports. In short, citizens should experience services as timely, flexible, responsive, and easy to understand and use.

An uncoordinated, unintegrated system is one that citizens experience as confusing and unresponsive because services are difficult to access and move between, and there are gaps and duplications. When systems are confusing and hard to navigate, the most vulnerable citizens – for example, people living in poverty, newcomers, and people with complex needs – will fall through the cracks.

Recent policy directives are acutely interested in advancing and improving health system integration. *Open Minds, Healthy Minds*[5], Ontario's mental health and addictions strategy advances four priority goals:

1. Improve mental health and well-being for all Ontarians.
2. Create healthy, resilient, inclusive communities.
3. Identify mental health and addictions problems early and intervene.
4. Provide timely, high quality, integrated, person-centered health and other human services.

The last goal promotes service integration and focuses squarely on timely access to the "right mix of supports". The plan calls for integration of mental health and addictions services, along with other service areas, including housing, income support, employment, and the justice system. This goal links to more specific benefits, such as shorter wait times, fewer emergency department visits, appropriate linkages from the justice system, better quality of life, and a lower per person cost of services.

Greater integration is also called for in *Ontario's Action Plan for Health Care*[6]:

> "There are still too many instances where patients don't know how to access the care they need, and don't know what services are available… Better integration through our local health networks will put the right care in the right place for the benefit of patients and the system….we need a patient-centred system that has better integrated health providers that moves patients more seamlessly from one care setting to another." (p. 5)

Calls for greater integration are echoed nationally, including recommendations from the Mental Health Commission of Canada[7].

In some jurisdictions, the main problem is a significant lack of services. Locally, for example, there are few services in Caledon, a predominantly rural area of Peel that is quickly evolving into populated suburbs. Brampton and Mississauga, the urban/suburban centres of Peel, are also lacking services that are proportionally necessary to meet the needs of a large and growing population. Locally, the funding levels of the Local Health Integration Networks (LHIN) responsible for Peel Region are low. For example, CCACs serving the Mississauga-Halton and Central-West LHINs received the lowest per capita funding in the province, ranking them at 13 and 14 of the 14 provincial LHINs.[8]

Funding priorities and allocations for mental health and addictions are different between the two LHINs, leading to potential service inequities in different parts of the region. This problem, of course, is an artifact of provincial health governance, which draws some arbitrary boundary lines through communities. Funding coordination between the two LHINs will continue to be an important ingredient for effective system

[5] Government of Ontario (2011). *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*. Toronto, ON: Queen's Printer for Ontario.
[6] Government of Ontario (2012). *Ontario's Action Plan for Health Care*. Toronto, ON: Queen's Printer for Ontario.
[7] The Standing Senate Committee on Social Affairs, Science and Technology (2006). Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada. Chaired by The Honourable Michael J. L. Kirby. Ottawa, ON: Author.
[8] CCAC funding levels were provided by the Fair Share Task Force, United Way of Peel Region.

integration. Both LHINs are dedicated to promoting system integration, continuity of care, and quality outcomes for residents. LHIN representatives sit on the advisory committee of this project.

In addition to Ministry of Health funding, there are other sources of mental health and social service funding. United Way of Peel Region, for example, funds a range of organizations that have a strong health promotion and wellness focus, supporting programs that strengthen the assets of individuals and communities. The Region of Peel is a significant contributor to the array of local social services, all of which relate to mental health and wellness. Peel Public Health, for example, delivers a range of health promotion programs to young families, focused on parenting and positive early childhood development. The Region of Peel Human Services delivers Ontario Works, which consistently links residents to other services, including mental supports. It also operates a social housing function in the region, which includes emergency housing and shelters, and partners with Canadian Mental Health Association (CMHA Pee) l to provide street-based outreach. The ROP Human Services also provides a range of early learning and child care programs.

Other sources of mental health funding are inconsistent and sporadic. Some organizations may supplement their operations with funding from other charitable organizations, private interests and/or government (provincial or federal) granting programs.

PROJECT DESCRIPTION AND PURPOSE

United Way contracted with Taylor Newberry Consulting to conduct a mapping of mental health and related services and resources in the region. The project was designed to identify gaps, barriers, promising practices, and key recommendations associated with navigation and access.

In addition, United Way has identified cultural diversity in the region as a central consideration when examining service navigation and access. United Way has three community advisory councils representing South Asian, Chinese, and Black communities. Each of these councils is responsible for community outreach and planning in order to gather a deeper understanding of the needs and strengths of residents. Each council has identified mental health issues, especially challenges in service navigation and access, as priority areas for their respective communities. Locally, it is well-known that people from diverse ethnocultural and linguistic backgrounds are more likely to experience barriers to service navigation and access.

As this report will show, there are many areas in which the mental health and addictions system - and social services more generally - can be improved. Many different organizations and sectors are implicated. Based on community need and the investment strategy, *the improvement of mental health service navigation and access, especially in relation to people from diverse ethnocultural backgrounds*, is a central goal of United Way. It has been recognized in Peel that, for many residents, initial contact with mental health services does not occur through the channels intended by the system – the “front doors” of mental health organizations. On

the contrary, people struggling with mental health and addictions issues tend to be identified through other social services, such as family services, newcomer settlement agencies, employment agencies, income support, or through community specific gatherings, such as faith groups or recreational settings.

Clearly the "mental health system" is much wider than the standard complement of mental health service organizations. Workers on the front lines of community and social services are often finding themselves unable to meet the needs of people struggling with mental and addiction issues. It is difficult to know how to effectively connect people so they can get help. These varied "places of contact" are particularly important as they represent opportunities for prevention and early intervention for people who are not yet in mental health crisis, but are experiencing levels of stress and anxiety that, coupled with difficult life circumstances, put them at great risk of mental health deterioration.

Through United Way's longstanding funding and project-based relationships with a large cross-section of local organizations, they have been made acutely aware of these needs. Mental health and addictions issues are truly cross-sectoral and shared by all organizations that contribute to different aspects of individual, family, and community wellness.

United Way aims to play the role of a *convening* organization. To date, the project experience has already demonstrated a local commitment to multi-stakeholder collaboration and dialogue to improve many parts of the system – parts of the system over which United Way can have little direct impact without the leadership of others. As United Way works with its partners to pursue improvements to navigation and access from a diverse ethnocultural perspective, it is hoped that the project findings and recommendations will stimulate a wider range multi-sectoral dialogue and actions to improve many different aspects of the local system. United Way is committed to facilitating continuing discussions where possible.

OTHER RELATED INITIATIVES IN PEEL

There are a number of other projects in Peel Region that are specifically examining system mapping and coordination of mental health and addictions services. They share similar goals as the present project, but tend to focus more particularly on certain populations or service areas. For example:

- The Centre of Addictions and Mental Health (CAMH) is leading the Peel Service Collaborative, with a priority on youth mental health. This multi-organizational system level initiative is focusing on, "Ensuring high-quality transitions from community and hospital and hospital and community that are respectful of and responsive to the diversity of Peel." There are cross-appointments on the project committees to ensure communication, sharing and consistency of messages.
- The Central West LHIN has established a working group of LHIN representatives and providers to identify opportunities and strategies to reduce mental health related repeat visits (within 30 days) to hospital emergency departments. This has included a consultation and mapping session with crisis

service staff in the region and other stakeholders. Potential changes involve new follow-up call protocols, standardization/implementation of crisis planning, and standardization of discharge procedures.

- Catholic Crosscultural Services[9] led a project to identify the needs of settlement workers to better support the mental health needs of newcomers. This resulting report was central in identifying the needs of diverse ethnocultural communities in Peel. The present system mapping is continuing to elaborate these needs.
- Canadian Mental Health Association (Peel Branch) led a consultation regarding mental health court supports and related mental health and justice diversion services. This involved a mapping of the core services that link mental health and justice issues.

Efforts have been made to ensure there is sharing of information between projects and clarity on how different initiatives can be mutually reinforcing. For example, it was beyond the scope of this project to examine children and youth mental health services. The issue of youth transitions is an important component of adult mental health and did enter our many conversations in this project. It is helpful that the Peel Service Collaborative is looking at these issues. This project will continue to promote cross-project collaborations where possible.

We now turn to a description of project structure, phases, and methods.

PROJECT GOVERNANCE

An advisory committee was assembled to inform the purpose, scope, recruitment, and methods of the project, as well as to help promote project activities and build connections with community stakeholders. The committee included representation from United Way management and community advisory councils, Peel Newcomer Strategy Group, Local Health Integration Networks, Region of Peel, Canadian Mental Health Association, Trillium Health Partners, Catholic Crosscultural Services, and several other community stakeholders. The committee met several times with Taylor Newberry Consulting to set project design, check on progress, and to review findings and recommendations.

PRIORITY QUESTIONS

The project sought to answer the following major questions:

1. What does the mental health system look like in Peel Region? What are the main service types and sectors? How do mental health services relate to other social service and health organizations and sectors?

[9] In partnership with Catholic Family Service Peel-Dufferin and COSTI Immigrant services.

2. What is the typical or common flow of people into, through, and out of the system? What are the circumstances of initial contact with the system? What are common referral pathways?
3. What are the barriers, challenges, and gaps in the system in relation to navigation, access, and continuity of supports? When and where do referrals and connections break down?
4. How is the system experienced by different ethnocultural groups, specifically South Asian, Chinese, and Black communities?
5. What are some key opportunities and recommended options to address these challenges and improve navigation and access?

PROJECT SCOPE AND METHODS

SYSTEM MAPPING AS AN ANALYTIC TOOL

In a well-functioning, coordinated system, residents are aware of and know how to locate available supports and services. Supports and services are readily accessible and comprehensive in meeting a range of needs without duplication. Organizations and programs communicate well with one another to ensure seamless movement throughout the system. Referrals in and out of programs are consistent, timely, and flexible.

In reality, large complex systems are rarely coordinated in this highly effective way, despite the fact that a wide range of programs and services target the same population. Although the success of a service very often relies on the coordinated efforts of related organizations, service integration is very often lacking.

To improve system-wide coordination, an important first step is to understand the barriers and gaps in a system that prevent residents from navigating and accessing the supports they need. A useful tool is “system mapping”.

System maps are not an inventory or list of service categories and organizations, although the term is often used this way. System maps are more detailed and dynamic than a descriptive list, attempting to display the common (or intended) flow of a user, beginning with first contact and access to services and supports, followed by any additional short- or longer-term supports that may subsequently follow. The goal is to illustrate the key “junction points” that people must go through in order to receive intended supports. This provides a visual representation of different parts of the system in order to analyze common practices: where the system is working well, and where it is breaking down. System maps are an important first step in identifying system gaps and barriers, and opportunities for improved integration, coordination, and access.

Maps can be created using different sources, such as formal program descriptions and policy documents. The most informative approach is to conduct in-depth interviews and focus groups with system stakeholders who have intimate, ongoing, day-to-day experience with how the system operates. Stakeholders are typically front-line workers and managers of the multiple organizations and groups that make up the system. In addition,

service users can also relate their direct experiences with the system. This project utilized multiple interviews and focus groups in order to understand service pathways through several related sections of the larger system.

PROJECT SCOPE AND BOUNDARIES

System mapping work has been conducted in Peel Region in the past. For example, mapping exercises have looked at crisis, mental health and justice diversion services.[10] The current project aimed a little more broadly and moved beyond organizations/sectors that are specifically focused on mental health to include newcomer and settlement organizations, family/neighbourhood health organizations, emergency shelters, and education. United Way has recognized that for many community members in Peel, connections into mental health supports are less direct, and mediated by other community-based services.

The project scope was broad and focused on the following areas of mental health and social services, as shown in table 1.

Table 1 – System/Services Areas of Focus

System/Service Areas	Example services/sectors
First contact services associated with crisis, emergency, self-referral, or transitions.	Distress lines, mobile crisis, police, hospital emergency departments, emergency/crisis shelters, crisis counselling in post-secondary education.
Intermediate to longer-term mental health supports and services.	Case management, counselling, group programs, self-help, addictions services, supportive housing, dual diagnosis services, justice-related services.
Family health and community services, including culturally specific services.	Neighbourhood and family health centres, newcomer settlement agencies, other culturally specific social services.

In order to capture as much of the service system as possible, the present project focused on the following areas in creating the maps:

1. Map A - Mobile Crisis Intervention
2. Map B - Hospital Emergency, In-Patient and Out-Patient services
3. Map C - Outreach and Emergency Shelter Services
4. Map D - Case Management Services
5. Map E – Family, Neighbourhood, and Ethnocultural Services

In addition to these maps, the analysis also focused on the rural context in Peel (focusing on Caledon) and, more general, how Peel residents can most easily connect to mental health services and supports. These maps and the related analysis provide comprehensive coverage of the system overall, involving many different service and program areas.

[10] Newberry, J. (July, 2008). System Mapping for Mental Health and Justice Diversion Services in Peel Region. Final report prepared for the Canadian Mental Health Association, Peel Region. Kitchener, ON: Centre for Community Based Research.

The scope of the project set some limitations. There was a dedicated focus on adult mental health services (and the organizations that directly interrelate with these services), with particular attention paid to ethnoculturally diverse communities. There is not a direct focus on several other important areas of need, such as youth transitions, dual diagnosis, seniors, or those in conflict with the law. These areas are complex in their own right and beyond the capacity of this work to fully investigate. They are, however, implicated in different ways within the priority maps.

We also note that it is *not* the intent of this work to map the referral practices and barriers associated with *specific organizations*. Rather, the focus will remain on distinct *types* of services or organizations. In some cases, the service type is delivered by one particular organization, and so we will sometimes be talking about individual organizations (e.g., Saint Elizabeth Health Care delivers Mobile Crisis and Crisis Outreach and Support Team (COAST); Spectra delivers the primary distress line).

PROJECT METHODS AND SAMPLING

The project information was gathered through a combination of key informant interviews and focus groups. The advisory committee assisted Taylor Newberry Consulting in developing a preliminary list of prominent organizations and high-level contacts that fell within the sector/service areas of interest. Leaders of selected organizations were invited to participate in a key informant interview. If appropriate, they were also asked to assist in assembling their staff for a front-line focus group. Sampling for interviews naturally snowballed – as we learned new information in the interviews/focus groups, new participants were identified. Table 2 (next page) provides the participation rates in the research. These numbers do not include the multi-stakeholder input gathered via the project advisory committee.

The focus groups were a facilitated session in which participants contributed to the creation of a system map representing the flow of people into and out of services and supports. These diagrams were created on whiteboards or banner paper. Participants were then able to comment on specific barriers to access and navigation that occurred within the varied connections that were displayed.

Interviews and focus groups were audio-recorded and transcribed. Analysis proceeded by coding the interviews according to common themes that were organized around: a) referral pathways into and out of services and b) challenges, gaps, promising practices, and recommendations.

Users of mental health addictions services did not directly participate in this study. However, this project was informed by an extensive community consultation recently conducted by United Way regarding mental health services and the challenges experienced by individuals when navigating the system. This information helped frame the questions of the project and contributed to our analysis of challenges in the system and ways to

improve it. Resident voices were also represented through the use of secondary data provided by the Central-West LHIN, based on a survey of local consumers who have used hospital emergency services.

Table 2 – Summary of Project Participation

	Focus Groups	Interviews	Participants	Organizations
Number	8	22	80	40
Participating Organizations	Angela's Place Caledon Community Services Caledon Parent and Child Services Caledon Victim Services Centre for Addiction and Mental Health – Dual Diagnosis Canadian Mental Health Association Peel Catholic Crosscultural Services Catholic Family Counselling Dixie-Bloor Neighbourhood Centre Elizabeth Fry Society Family Transitions Place India Rainbow Central-West LHIN Malton Neighbourhood Services Mississauga-Halton LHIN Newcomer Centre of Peel Our Place Peel Peace Ranch Peel Addictions Assessment & Referral Centre Peel Children's Centre Peel Chinese Community Service Hub		Peel District School Board Peel Newcomer Centre Peel Newcomer Strategy Group Punjabi Community Health Centre General Physicians Reconnect Regeneration Outreach Community Region of Peel (Outreach, OW) Saint Elizabeth Health Care Spectra Community Support Services St. Leonard's Place, Peel Supportive Housing in Peel Trillium Health Partners University of Toronto – Mississauga United Achievers United Way of Peel Region United Way of Peel Region Advisory Councils Victims Services of Peel Vita Centre William Osler Health System	

GAPS IN OUR SAMPLE

While a comprehensive cross-section of representatives was accessed, there were some gaps in the project, simply due to project time frame and capacity. We hope to address these limitations in later phases of this work.

Family members: While one family member participated as a key informant, family groups will also need to be consulted in future phases.

Faith groups: Faith groups are often the first place where vulnerable individuals are identified. Faith leaders can play an important role in linking people to appropriate services and, perhaps more importantly, can function to dispel myths, educate, and foster an anti-stigma perspective on mental illness.

Community Health Centres: While we did talk to a number of neighbourhood centres with health mandates, health-funded CHCs were not included in this project. They are another important access point for mental health and addictions services.

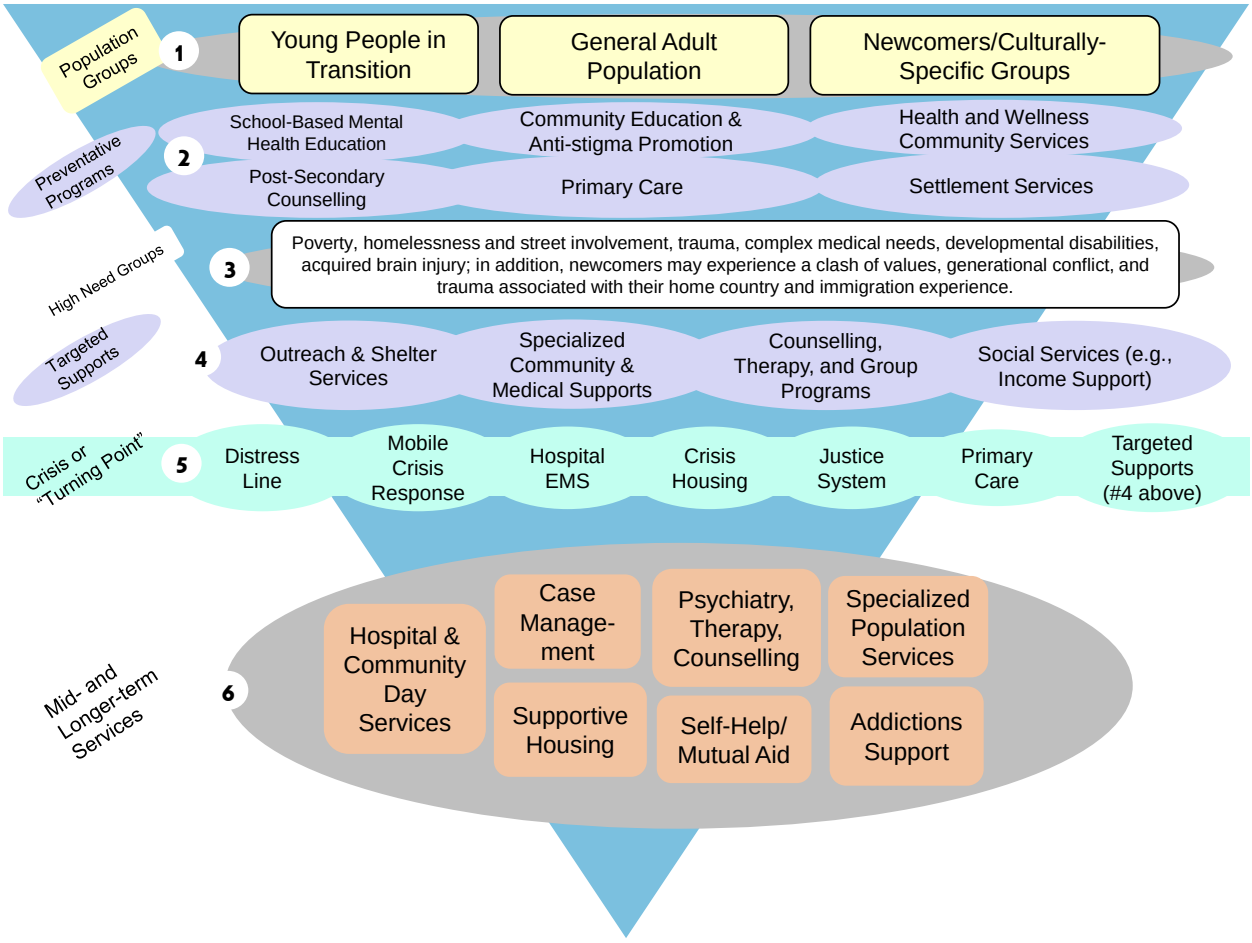
Family and Children's Services: Family and children's services, such as Children's Aid, are often a first contact for families experiencing struggles, but were not included in this project.

MENTAL HEALTH AND ADDICTIONS – THE LANDSCAPE IN PEEL

Before reviewing the individual system maps, it is helpful to first provide an overall rendering of the mental health and addictions system. Figure 1 (next page) provides a general representation of adult mental health and related supports and services. It is not exhaustive; however, it captures the main features of the system in Peel Region within the boundaries of this project. It will also aid the reader in situating the more specific parts of the system that appear in our maps. The diagram appears in six interrelated rows.

1. *Population Groups*: The top row refers to the main populations of interest in this work (*Adults in Peel Region*) with specific attention to culturally-specific groups, and to a lesser extent youth in transition.
2. *Preventative Programs*: The second row refers to the range of programs that are in place to promote health and well-being, and prevent mental health and addictions difficulties before they fully emerge among the general population. For example, educational campaigns and programs seek to raise awareness about mental illness and reduce associated stigma. Many programs from an array of community social services exist to promote health and wellness. Settlement and culturally specific services target the needs of new Canadians of many backgrounds by providing ESL, vocational training, health and wellness services, etc.
3. *High Need Groups*: The third row identifies a number of experiences, conditions, and circumstances that place people from the general population at a much higher risk for mental health difficulties.
4. *Targeted Social Services*: The fourth row specifies some broad service categories that are available to individuals who exhibit greater risk for mental health crisis and difficulties, due to the conditions above. For example, specialized supports are available to individuals with complex needs, such as developmental disabilities or acquired brain injury; outreach programs and shelters seek to meet the needs of homeless and street-involved individuals; various family and individual counselling programs are available for a range of issues; finally, other social services exist to help individuals who are experiencing difficulties, such as income and vocational supports, affordable housing, etc.
5. *Crisis or "Turning Point"*: The fifth row represents those parts of the system that are designed, in whole or in part, as an entry or linkage point into specific and dedicated mental health and addictions services. This part of the system typically represents a crisis or turning point of some sort, either due to an acute crisis event, self-referral, or direct linkage into mental health services by other services (e.g., from the targeted supports in #4).
6. *Mid- and Longer-Term Services*: The final row represents the range of dedicated mental health and addictions services, including hospital- and community- based, supportive housing, psychiatry and counselling, addictions, and specialized services associated (e.g. acquired brain injury, dual diagnosis, geriatric, etc.).

Figure 1 – The Main Features of Peel Region's Mental Health and Addictions System (see text for explanation)



This broad representation of the system does not identify specific referral pathways, or help us to identify specific challenges and barriers in the system. Rather, it shows in general terms the main categories of service and supports and how they are roughly arranged according to population levels – from universal and preventative (for the population as whole) to targeted (for those at risk or already experiencing mental difficulties).

The system maps, however, drill down to provide more detailed information regarding the challenges to navigation and access in the system. Maps are labelled with numbers that correspond to challenges/barriers in different parts of the systems. These are listed in the body of the report as A.1., A.2., etc., referring to the numbered barriers on Map A. Recommendations are listed as AR.i., AR.ii., AR.iii., etc., to refer to the list of recommendations associated with Map A. All the recommendations are consolidated in abridged form in Appendix A for easy reference.

ETHNOCULTURAL DIVERSITY AND OUR ANALYTIC APPROACH

"*How is the system experienced by different ethnocultural groups, specifically South Asian, Chinese, and Black communities?*" This is a priority question for each of the three community advisory councils representing these ethnocultural groups at United Way. Our key informant interviews and focus groups targeted staff and managers of organizations that serve these populations. We also talked to providers and organizations who provide ethnoculturally specific services as part of their mandates. Depending on the interviewee, we asked questions about the experiences that may be specific to each of the South Asian, Chinese, and Black communities.

It became clear in this analysis that it is problematic to treat broad cultural groups – in this case, South Asian, Chinese, and Black communities – as homogeneous. South Asia, for example, is composed of nine countries[1] and is home to numerous languages and several major religions. The differences based on many subgroupings are significant and speaking about the "South Asian experience" in relation to mental health service access is inappropriate. The same issue is applicable to Black and Chinese populations. In addition to a "within-group diversity" of language, nationality, and religion, there are other factors that can profoundly affect a person's experience of the system. Length of time in Canada, and level of acculturation and familiarity with the Canadian context matters immensely. An English speaking, third generation family originally from India who is well connected to the Peel community will understand and respond to the system differently than a very recent newcomer with the same cultural background. Age, gender, and generational factors matter, and these will also matter differently depending on, for example, family religion and religiosity.

What is key is that there are important broad commonalities that unite the ethnocultural groups in question. There is a general incompatibility between many non-western cultures and the dominant, westernized conceptions of mental illness, mental health, and the associated responses of the health and social service system. Barriers and gaps identified by key informants, from managers down to front-line staff, were oft-repeated:

- Language barriers in accessing services are prevalent. Speaking about mental health issues in English is frustrating for people with low English literacy.
- The westernized concepts of mental illness and mental health are unfamiliar to many people. Definitions of mental illness that are widely accepted in the system are inconsistent with the cultural understandings of many groups.
- There is individual and family stigma and shame associated with mental illness. Problems remain hidden in families and help is not sought out. Seeing a professional for mental health issues equates with "being crazy".
- The cultural competence of "mainstream" mental agencies is insufficient in meeting the needs of diverse cultural groups.

[1] Based on the United Nations geographical region classification.

- The dominant system is focused on individual treatment approaches with stringent expectations of privacy. In many cultures, a family level approach is desired or expected; individual, private treatment can be confusing and alienating to families.
- There is often significant family conflict that stems from an intergenerational tension between the home culture and Canadian social values and practices.
- Newcomers often exhibit experience stress, anxiety and depression associated with trauma in their home countries and feelings of isolation in Canada.
- The first point of access to potential supports is not via mainstream health services, but other community organizations, and often for other reasons (e.g., employment, ESL, education). These organizations often do not receive funding earmarked for mental health.

We found that regardless of the ethnocultural group in question, the challenges experienced in accessing and navigating services were highly similar and generally applicable. This is not to suggest there may not be specific and unique barriers based on cultural group membership. For example, it may be that, at a given organization, there are greater options for particular groups to obtain services in their home language as compared to others. Or it could be that some religious leaders and their congregations are more strongly connected to community services than are others. However, this project was not designed to delve into this level of specificity or to uncover the relative challenges and successes of *individual* organizations in meeting the needs of the many different cultural communities they serve. We were interested in how ethnocultural groups experience service types and the system as whole.

This research project aimed to generate such unique understandings; the result, however, was a set of repeated challenges in the system that cut across cultural backgrounds. However, we assert the system's response to these findings should be unique to cultural contexts and not generic. In efforts to improve the system, what will matter is the organizing and engagement of culturally specific groups and flexible funding models by a variety of funders at different levels of government and community. New improvement approaches need to include community leadership, community development models, and joint ownership among funders, mainstream organizations and ethnospecific communities. Translating and implementing general recommendations in ways that are consistent with the context and needs of the communities in question will be essential. We will revisit these issues in more detail in relation to Map E – Family, Neighbourhood, and Ethnocultural services.

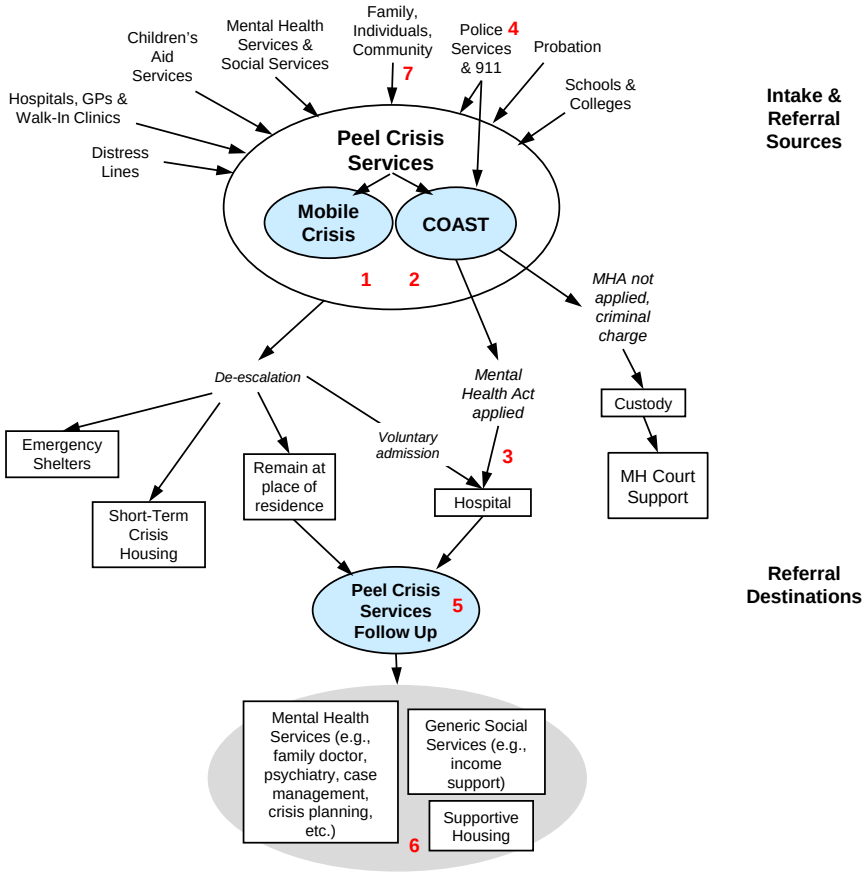
MAP A – MOBILE CRISIS INTERVENTION

Mobile crisis intervention is a core service area of any comprehensive mental health system. Please see Map A (below) for the corresponding system map. Effective crisis intervention is based on rapid assessment and response at the place where it is occurring, in an attempt to de-escalate acute difficulties and divert from admission to hospital, followed by counselling, information, and referral. In a partnership between the

Canadian Mental Health Association - Peel Branch, Saint Elizabeth Health Care, and Peel Regional Police, the region adopted a “Crisis Outreach and Support Team” model (or COAST) to enhance their mobile crisis service.

COAST is modelled after best practices that have been developed in other Canadian communities (e.g., COAST Hamilton). A COAST team is mobile and composed of a mental health professional and plain clothes police officer, and is designed to respond to high-risk mental health crisis that may require formal police intervention. The COAST model is more effective at de-escalating crisis since it does not require the intervention of uniformed officers and police cruisers, which may often intensify stress and crisis. COAST also reflects a strong partnership and enhanced information sharing between police services and community mental health services in order to more effectively respond to calls.

Map A – Mobile Crisis Intervention



In Peel Region, crisis intervention is accessed through a number of referral pathways. The top portion of the map lists some of the most common referral sources, all of which connect to Peel Crisis Services through a centralized phone number. Intake proceeds by conducting a quick assessment of the situation whereupon a decision may be made to send out a regular mobile crisis team or, in the case of high risk situations (e.g.,

known history of violence or aggression), a Crisis Outreach and Support Team (COAST) team. It should be noted that if there is a clear criminal element to the situation, a conventional police unit is dispatched.

COAST does not serve Caledon; Mobile Crisis serves the area and high-risk calls are answered by Ontario Provincial Police (OPP). CMHA has trained the local OPP on mental health crisis intervention to improve community response.

There are three broad responses/outcomes to a crisis intervention call. The first, the preferred option, is that the crisis situation de-escalates, with the intervention of a Mobile Crisis or COAST unit. In some cases, a mobile response may not be required. When a crisis is de-escalated, the individual typically stays at their place of residence or, if housing is not available, they may be taken to short-term crisis housing or emergency shelter. A second outcome, through the intervention of COAST, is that the individual is apprehended under the Mental Health Act and taken to hospital for admission to emergency. A third outcome is that a charge is laid and the person is taken into custody; however, a regular police unit is required to carry this out.

Peel Crisis Services also provides follow-up support, typically 24-hours after crisis in order to provide additional support and provide linkages to other programs. St. Elizabeth Health Care provides referrals to their own programs (the concurrent disorders program with other partners, crisis management planning, and geriatric health) and to other community-based mental health services, supportive housing, and generic social services.

CHALLENGES IN THE SYSTEM: MOBILE CRISIS INTERVENTION

Based on our focus groups and interviews, barriers to accessing Mobile Crisis and COAST services appeared fairly minimal. COAST can be considered a best practice that greatly enhances crisis response in the region. There were some suggestions regarding challenges, however:

A.1. The capacity of Mobile Crisis/COAST could be increased. Peel Region is particularly large and the teams are centralized in Mississauga. **Long distances in heavy traffic can sometimes limit response time. The ability of Mobile Crisis to serve Caledon is limited.**

A.2. While Mobile Crisis provides 24/7 access, **the COAST team is only available from 11 a.m. to 11 p.m**. Crises often occur outside these hours.

A.3. Mental health apprehensions are proportionately low in relation to the total number a calls (a positive outcome that demonstrates emergency department diversions). When admission is necessary, however, **long wait times at emergency departments can interfere with subsequent COAST responses.**

A.4. The success of COAST in diverting from emergency departments does not reflect the fact that **conventional police units still must respond to a large number of mental health calls**, which have steadily increased from 2,478 in 2009 to 3,901 in 2013. In 2013, 86% of the calls resulted in apprehensions. This translated into 9,379 police-hours waiting in hospital, with an annual cost of almost $1 million.[11]

A.5. COAST **follow-up can be challenging, especially when individuals are transient and resistant to participation**. It is also more challenging to follow- up after hospital admission; there is a general lack of discharge planning and communication (see Map B).

A.6. **There are waiting lists for post-crisis referrals to external mental health services**.

A.7. **COAST reports serving a diverse cross-section of Peel's population**. Anecdotally, it was reported that the majority of calls are from the South Asian population, reflecting regional demographics. However, team members are concerned that feelings of stigma and family shame prevent many people of different cultural backgrounds from accessing the service.

RECOMMENDATIONS: MOBILE CRISIS INTERVENTION

The recommendations associated with mobile crisis intervention are associated with access and reach which, in turn, are associated with capacity.

AR.i. **Enhance the service so that it can be delivered 24/7. Expand reach** by adding teams that can respond to the large geographic area of the region and take some of the burden off conventional police units. Consider options for satellite offices (or temporary co-locations) in Brampton or Caledon.

AR.ii. **Coordinate discharge planning with hospitals to ensure COAST/Mobile Crisis teams can follow-up with individuals after discharge**. An expanded role of St. Elizabeth Health Care's follow-up services could be to take the lead of identifying a primary worker for individuals who enter hospital via the crisis service and are subsequently discharged (see Map B).

AR.iii. **Build dialogue and partnerships between COAST/Mobile Crisis and ethnospecific organizations and faith groups**. Community development strategies to reduce stigma and build mental health literacy (see Map E) are necessary to promote access to crisis services. Alongside such initiatives, COAST/Mobile Crisis will need to communicate and promote their service to improve access. Additionally, partnerships will also build greater opportunities for the service to connect individuals to culturally relevant community supports.

[11] Presented by Peel Police Services at H*ealthy Minds, Healthy People, Strong Communities: Physicians Conference*, June 6, 2013.

MAP B – HOSPITAL EMERGENCY, IN-PATIENT AND OUT-PATIENT SERVICES

Peel Region has four major hospital locations that serve Peel residents. William Osler Health System manages two hospital sites, Etobicoke General Hospital (residing just outside of Peel Region) and Brampton Civic Hospital, which primarily serve Brampton and Caledon. Trillium Health Partners manages two hospital sites, Credit Valley Hospital and Mississauga Hospital, which primarily serve Mississauga.

In addition to providing emergency crisis services, the local hospitals provide a wide array of in-patient and out-patient mental health services. Trillium also provides some examples of off-site community based programs, such as case management and Assertive Community Treatment Teams (ACTT), concurrent disorder program, and housing support, in collaboration with several other organizations.

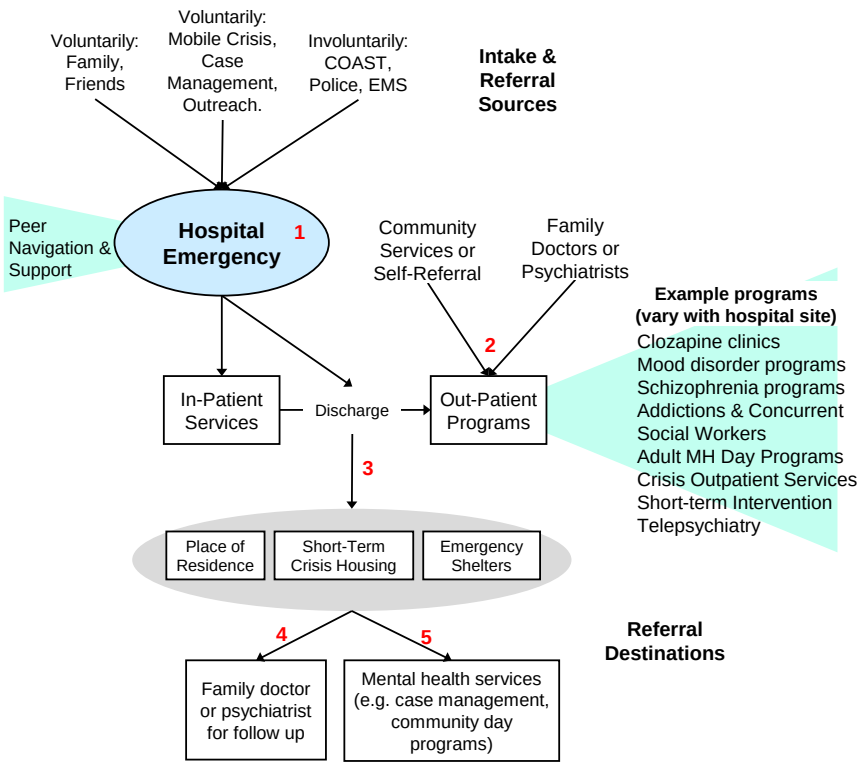
The accompanying system map (Map B, below) summarizes the intake and referral pathways for hospital-based services. Individuals experiencing mental health crisis enter hospital through emergency departments either voluntarily or by police apprehension (under the Ontario Mental Health Act). Involuntary admission is triggered by a Form 1 Assessment Order. After emergency department assessment, individuals are either discharged back out of hospital or admitted to acute in-patient services.

Upon discharge from emergency or in-patient services, individuals may link to hospital based out-patient services; otherwise they are discharged back to community. Discharge to community may include a formal referral process, but often does not.

There is a range of out-patient services available that vary depending on the hospital site. A list of examples is provided in Map B. Out-patient services are accessed, as mentioned, via in-patient services, and also through medical referrals from general physicians or psychiatrists. A small number of programs can be accessed through self or community referral.

All hospitals are looking at ways to streamline or triage mental health intake to reduce wait and assessment times. For example, William Osler has created an “in-patient, out-patient hybrid” for individuals who need intensive support but do not need formal in-patient admission. Such individuals must still go through an emergency admission, but they are subsequently discharged to a crisis service. This is technically an out-patient service staffed by mental health professionals, which lessens the pressures on in-patient beds and promotes more attentive quality care. This same site has a short-term intervention clinic where individuals who do not need admission can receive counselling service.

Map B – Hospital-Based Services



Other out-patient services are diagnosis-focused, targeting mood disorders, schizophrenia, or concurrent disorders, for example. The Trillium Mississauga site also has community-based services (adult mental health case management, case management for concurrent disorders, etc.) that can be referred to directly from their in-patient or out-patient services.

The range of in-patient and out-patient services available at the regional hospitals is considerable – it appears that all the hospitals have the capacity to provide an array of important clinical supports. The limitations of these supports are related to a number of gaps and challenges associated with referral, follow-up, and community access.

Hospital staff were also asked about their ability to meet the needs of diverse ethnocultural groups. The general response was that hospital programs have done a good job at promoting access through cultural sensitivity training, translation of health materials, and the availability of interpreters. Furthermore, front-line staff represents the cultural diversity present in Peel. Connections have been made with culture-specific organizations to understand community needs and expectations and to make organizational linkages for more effective discharge planning. There are also some innovative plans for “Peer Navigators” from distinct cultural

groups to meet individuals in crisis in hospital to help with explanation and interpretation, and to establish connections to community organizations. This is a promising new development.

CHALLENGES IN THE SYSTEM: HOSPITAL-BASED SERVICES

Information gathered in key informant interviews and focus groups (internal and external to the hospitals) suggested a number of key barriers and gaps in relation to this important component of the mental health system. These gaps/barriers were consistent with the findings of a local survey, conducted by the Central West LHIN, of 48 consumers who used hospital emergency services in the past year.[12]

B.1. **Emergency department wait times are excessive**. While this is a common problem across Ontario communities, Peel Region has particularly high volumes of emergency department admissions.[13] This can decrease quality and responsiveness of mental health care and also requires increased police resources.

B.2. **Hospital policies, with a few exceptions, require that referrals into their out-patient programs come from general physicians or psychiatrists**. The majority of referrals come from the hospitals' in-patient services. This means that **a potentially large number of individuals – those without a physician or psychiatrist – cannot access these services**. Only 31% of respondents to the consumer survey currently had a family doctor providing care. This barrier will disproportionately apply to poorer individuals and newcomers, who are less likely to be attached to formal medical services. Furthermore, it is unclear to what extent general physicians in Peel are aware of the range of out-patient services.

> "Sometimes when you have been informed that the client is there, there's a lack of partnership in the planning of the discharge. There's not always the best of connections. Sometimes you don't even know they've been hospitalized until you meet with them a couple weeks later." – Case Manager

B.3. In general, **there is a lack of formal discharge planning, referral and follow- up with individuals discharged from hospital.** The consumer survey showed that only 4% of respondents met with a discharge planner in hospital; 21% received information about community support options to follow up on their own; and 21% received a formal referral to community supports.

B.4. As mentioned, referrals may be made to the hospitals out-patient services, but people may not return to the service after discharge and there is little to no follow-up to encourage service use. There is a lack of understanding about where in the system people go after hospital discharge. While some respondents assume that individuals will visit their general physician (GP) or psychiatrist post-discharge, **many individuals either do not have these**

[12] Central West LHIN (2012). *Consumer Survey on Experience In Use of Emergency Departments*. Technical Report

[13] Based on interviews with hospital representatives.

formal supports or elect not to use them. GPs and psychiatrists will receive hospital reports, but this information may arrive weeks after the event – they may not even be aware that their patient was admitted to hospital. This barrier may be more problematic for some ethnocultural community members who will tend to **lack connections and familiarity with the mainstream health and social services that are common in discharge planning**.

B.5. Case managers and other community-based mental health providers also identified discharge planning as a gap. **Communication regarding the admission of a supported person is lacking and there are not enough formal connections to community-based and ethnocultural services.** This includes family health services, newcomer services, and other neighbourhood-based supports. The central gap in Peel is the lack of a detailed, well-resourced discharge strategy that ensures the individual is connected to supports once back in the community. This is crucial to prevent relapse back into hospital.

B.6. While a diverse cross-section of Peel residents access hospitals for mental health services, there was a general reported concern that **many people of different ethnocultural backgrounds would avoid hospital based services due to feelings of stigma and shame.**

It should also be pointed out that this map was created in relation to hospitals in Peel Region. We also know that some Peel residents, due to personal choice or physical location, will enter hospital outside of the region. Challenges in connecting individuals from these other hospitals to community services may be even more pronounced. More work will need to be done into the future to ensure that effective service connections are made with hospitals external to Peel.

A NOTE ON GENERAL PHYSICIANS AND MENTAL HEALTH IN PEEL

Parallel to this project, United Way in partnership with Dr. Colin Saldanha, Astra Zeneca and Canadian Mental Health Association, to a physician conference to promote awareness about mental health, mental illness and community based supports, brought together 40 local family physicians for an open forum regarding their relationship to mental health services and practices in the region. Attendees were able to identify their needs and concerns, and to provide feedback on the system. While the role of GPs is threaded throughout all the maps, it is being considered here, due to the primary care connection to hospital-based services. Feedback included the following:

> "There's still education to be had…we try our best to educate physicians in the area about what services are available to the patients." – Hospital Representative

- Due to a lack of resources, family physicians are treating patients with mental health issues beyond their comfort level. They need more follow-up and treatment options to refer their patients, such as day programs.
- William Osler has Telephone Psychiatry for family physicians with a response time of 1-2 days. This service is in Brampton, but not Mississauga. It is greatly needed region-wide.
- Family Health Teams and improved networks with psychiatry need to be increased in Peel.
- There is little follow-up after emergency discharge. Physicians need more timely information and support when their patients are discharged.

RECOMMENDATIONS: HOSPITAL-BASED SERVICES

BR.i. Reducing hospital wait times is a challenging problem experienced by many hospitals in Ontario and elsewhere. It will be important to see what recommendations the Peel Service Collaborative provides in their own work. In general, however, **hospitals should continue to explore ways to triage and divert individuals in crisis from regular emergency admission pathways**. William Osler's hybrid out-patient clinic is one example, although regular medical clearance in emergency is still required. Triaging individuals through a separate admission process (procedurally and also in relation to the physical space) so that crisis is addressed as quickly as possible by mental health professionals is recommended. This would likely lessen in-patient admissions, take pressure off the emergency department, and free up police officers, Mobile Crisis, and COAST teams.

BR.ii. A priority recommendation is to **develop a discharge planning framework at all four hospital sites.** A central function of a discharge plan is to identify a primary worker for every person who enters emergency in mental health crisis, regardless of whether they are formally admitted. A primary worker is responsible for establishing an immediate connection with the individual, as soon as possible upon arriving at hospital (i.e., discharge planning begins at admission). Until a primary worker is identified, out-patient hospital programs should take this role. **A promising practice is to embed a mental health worker from a community-based organization directly in emergency and in-patient services.** This individual would lead discharge planning and make direct connections to community based and ethnoculturally-specific services. **A subsequent primary worker after discharge should also be community-based** – it is insufficient to designate a general physician or psychiatrist, although discharge plans should always identify and communicate with these parties if they exist. A discharge planning framework may involve many different organizations, which requires significant hospital-community collaboration and resource allocation. However, discharge planning represents a significant gap that can be addressed through coordinated efforts. It is particularly important to apply resources to this area

because hospital emergency is a place where individuals in need can be directly accessed; connecting individuals in need to other services may in turn reduce return visits to hospitals.

BR.iii. **Out-patient services should open up referrals from other sources, beyond family doctors and psychiatrists only**. This may require added resources to conduct assessments (i.e., to ensure program eligibility) but this is a basic necessity (and not a good reason to narrow referrals). Wait lists (which already exist) may increase so it will be important to ensure that community referrals do not fall by the wayside (e.g., because in-patient referrals demonstrate program eligibility more readily than community referrals).

BR.iv. **Family doctors need greater access and information for mental health and addictions support**. Telepsychiatry via hospitals to support physicians should expanded region wide.

BR.v. **Peer navigation as a hospital service should be explored**. Peer navigators can represent a range of cultural and community groups (including consumer self-help) and can therefore help establish connections to community and ethnoculturally-specific supports. Navigators would also be a part of discharge planning processes.

Peer navigation in hospitals has been successfully developed in other jurisdictions. In Waterloo Region for example, peer navigators are hired by local hospitals but also supported (for training and support) by the Self Help Alliance, a consumer-led organization. A similar model in Peel could include peer navigators from cultural- and language- specific organizations.

The navigator role is more than a useful "add on" to hospital services; it is a significant undertaking that requires hospitals to integrate and incorporate non-professionals into the health care sphere. For more information on the principles and practices of peer support workers in the mental health services, please see www.self-help-alliance.ca.

MAP C – OUTREACH AND EMERGENCY SHELTERS

A community mental health perspective recognizes that homelessness and mental illness are both multi-determined.[14] Economic barriers, marginalization, racism and exclusion, and other social factors can lead to unemployment and homelessness. The extreme stress, anxiety and trauma associated with poverty can lead to mental breakdown and substance use. The reverse may also be true, as people with severe mental illness have difficulty maintaining employment and financial stability, leading to economic dependency and homelessness. Regardless of the causal relationships, we know that people who are homeless are more likely to experience mental health difficulties and that the experience of homelessness exacerbates these challenges.[15]

[14] Canadian Institute for Health Information (2008). *Improving the Health of Canadians: Mental Health and Homelessness*. Ottawa, ON: Author.

[15] Public Health Agency of Canada (2006). *The Human Face of Mental Health and Mental Illness in Canada*. Ottawa, ON: Minister of Public Works and Government Services Canada.

When addictions, trauma, and overall risk for mental health crisis are also considered, the homeless and street-involved population is clearly a priority focus of mental health systems in Ontario. Locally, Peel Region has developed a set of outreach and shelter services to attempt to reach and support the most vulnerable residents. These are displayed in Map C on the next page.

A combined focus group accessed street outreach workers and emergency shelter workers. These two groups were brought together because they routinely provide support to this vulnerable population of individuals in the region. The group led to the generation of a system map that covers this important part of the system (see Map C, above).

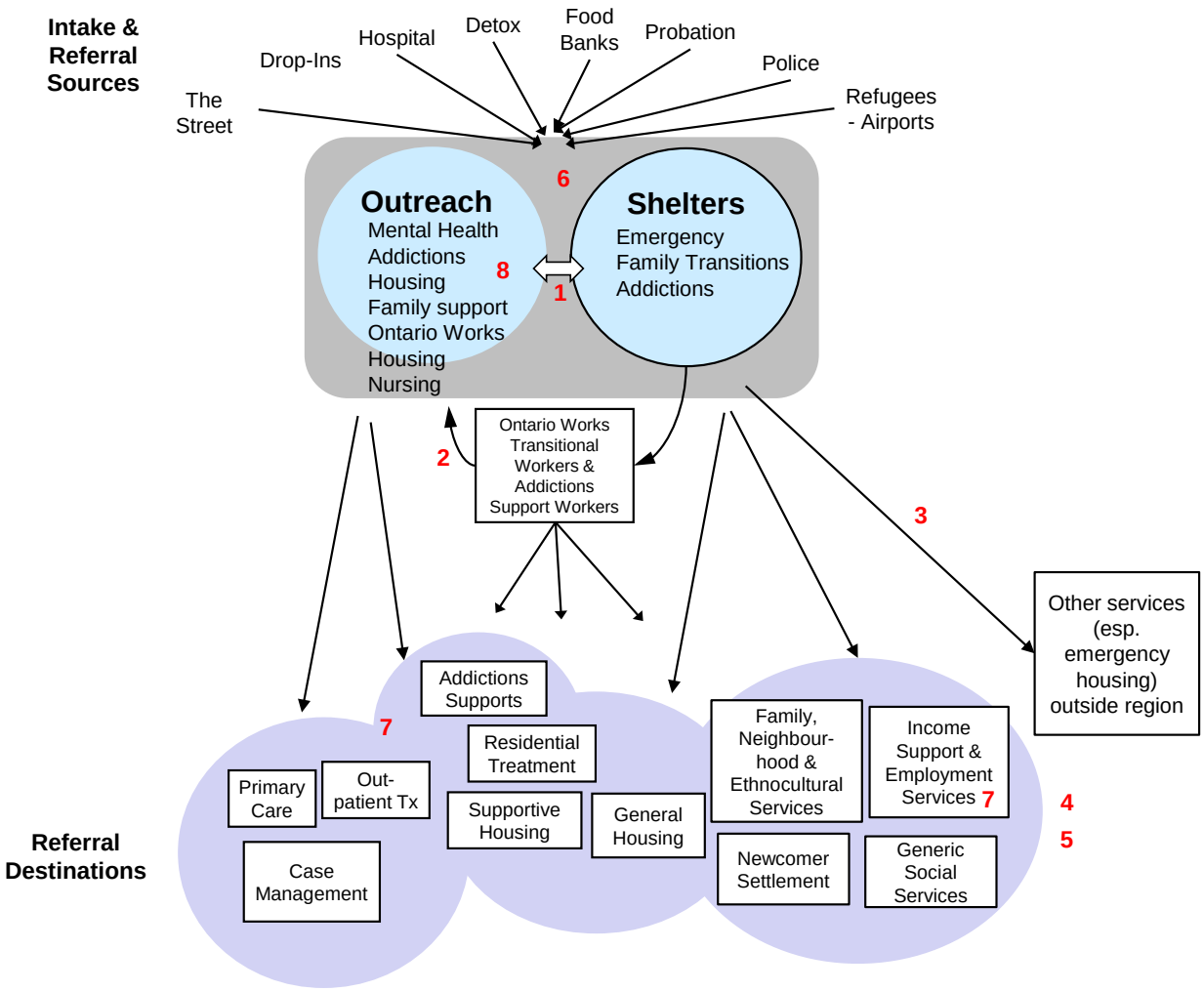
Street Outreach Workers – These workers fulfil a set of outreach service functions under a partnership between Region of Peel Social Services and the Canadian Mental Health Association (Peel Branch), Peel Addiction Assessment and Referral Centre, and St. Leonard's Place Peel. Service components include Ontario Works (OW), transitional supports, mental health support, public health, and substance use. Services are mobile and accessible seven days a week.

Emergency Shelter Workers - There are three large shelters in the region (one serving men, one serving women or couples, and one serving families), plus several other smaller organizations provide emergency or transitional housing support for women, children, and youth. Workers in shelters provide support related to basic needs, housing, income, food security, employment, and addictions. Each shelter has an OW case worker attached to it who works directly with individuals who receive OW benefits.

Individuals become connected to outreach or shelters in a variety of ways. The most common are listed at the top of the map and include drop-in programs, hospitals, detox centres, food banks, probation, police, or simply at "hotspots" and common gathering places on the street.

Shelter and outreach workers link to each other's services – outreach teams often engage with individuals who need emergency housing; and individuals are often linked to the outreach team upon leaving the shelter. Both shelter and outreach workers attempt to link individuals to other supports and services. Ontario Works transitional workers also work with shelter residents to meet a range of needs associated with income and housing. These functions appear in Map C along with a number of referral destinations, including primary care, case management and out-patient services, addictions support and residential treatment, supportive housing, general housing, health services, newcomer settlement, income support and a range of generic social services.

Map C – Outreach and Emergency Shelter Services



The strengths of outreach and shelter services flow from their multi-organizational and multi-disciplinary character. There are many service types and specializations available to individuals at this level of need. This cluster of services is resourced by a regional partnership that unites several key organizations responsible for mental health, addictions and housing supports under a municipal umbrella.

While we acknowledge the strengths of these service areas, there were also a number of challenges and gaps that were identified. Some of these are due to the challenging nature of working with individuals with serious and complex needs. Other barriers are linked to practical or policy-based issues.

CHALLENGES IN THE SYSTEM: OUTREACH AND EMERGENCY SHELTERS

Respondents identified a number of challenges in working in this area of the system. Many of the challenges relate to the presence of service boundaries and limitations that become part of regular practice.

> "Outreach workers are not working in shelters because there are similar workers in there, which is seen as duplication "
> Outreach & Shelters Focus Group

C.1. **Outreach workers do not generally go into shelters to work with individuals because this is viewed as a duplication** of the shelter workers' role. However, shelters do not provide the mental health support that is available through the outreach team.

While outreach and shelter functions make referrals to one another they lack team-based coordination. The outreach team must "start anew" with a person leaving the shelter; support provision is conceded to shelter staff if the person re-enters the shelter. This **lack of coordination can translate to repetitiveness and a lack of continuity of supports for individuals**.

It is noted that many shelter users are supported by Ontario Works transitional workers who provide a range of support inside and outside the shelter. In such cases, there is greater continuity of services regarding income support, employment, housing, and other needs (but see C.2., below)

C.2. If an individual in the shelter uses OW, they will have a dedicated OW case worker[16] assigned to them. **It was the perception of shelter staff that all referrals must go through the assigned worker. This prevents direct referral to the outreach team (such as when they leave the shelter). This perception of staff is at odds with the policy of the Region, which explicitly defers referral planning to shelter staff, rather than the worker.**[17] There is a need to revisit practices to ensure that roles and responsibilities are understood by all involved and aligned with policy directives.

C.3. Due to a range of circumstances, **some individuals must be rejected from services in the local community and have to get services and supports outside the region**, most prominently emergency housing. This may happen when individuals are banned from local shelters due to past violence and aggression, complex needs that cannot be met, or because of drug and alcohol use. There are no shelters that support individuals with alcohol addictions in Peel.

[16] In this context, Ontario Works case workers may be Transition Workers or Addictions Support Workers, the latter being part of the Ontario Works Addictions Support Initiative (OWASI).
[17] Region of Peel (2012). *Emergency Shelter Standards*. Regional policy guidelines, p. 25.

C.4. **Wait times for many community supports and services are long**. The probability of individuals remaining in contact over the wait period is much lower, due to transience and rapidly shifting life circumstances.

C.5. **Many services have eligibility criteria that may exclude individuals from this population.** Simple issues like having suitable identification, a contact phone number, and a fixed address can render a person ineligible. Failure to keep appointments at office-based service locations may lead to people being dropped from the service. Some services may exclude based on policies regarding complex needs (e.g., addictions, developmental disability) and low tolerances for perceived risk. Long assessments may intimidate people and discourage participation.

> "The service that the transitional worker providing is OW, not mental health and addictions. The shelter is obligated to refer to OW first, but OW workers are not addictions and mental health workers so the client is not getting that support --- just financial support from OW. It's the transitional worker who decides if they bring in MH&A services at all "
> Outreach & Shelters Focus Group

C.6. The challenge of providing comprehensive supports (due to the reasons in C.4., C.5., and others) leads to **a difficult cycle where unmet needs lead to a continual demand for emergency shelter services and mental health support via outreach**. This problem is particularly pronounced when supported or affordable housing is difficult to acquire and maintain. This is a common challenge in Peel Region.

C.7. There was a general perception **that OW or Ontario Disability Supports Program (ODSP) workers not formally connected to the outreach or shelter services can be difficult to access.**

C.8. In general, this population of **individuals is resistant to participating in mental health services.** Many individuals have been historically detached from formal services and may be quite suspicious or threatened by the idea. Meeting their needs may require long periods of trust and rapport-building. Transience and attrition from services is very common.

C.9. **Accessing diverse cultural communities and being seen as an ally is a challenge due to mistrust, stigma and fear**. Some cultural communities **do not recognize mental health and addictions as an issue** so it is challenging to gain participation in services. In support relationships, community members **prefer workers from their own background**; outreach and shelters are often unable to match this preference.

C.10. **Some cultures prefer family-level support.** This presents challenges to delivering services that are individually focused.

C.11. Some service users want to talk about systemic oppression that relates to culture. **Staff do not always feel equipped** to participate in that type of dialogue.

C.12. Outreach, by its nature, is designed to be low intensity. It is often characterized by "on the street" check-ins and trust-building. It may take a long time to forge a strong connection with an individual before mental health supports are even offered. For this reason, the number of people seen by a street outreach worker can be quite high. In Peel, **outreach workers have noted that they are filling a case management function with some individuals, meaning a greater intensity of support is required.** This is to ensure people's needs are met when they cannot access longer term supports. This means that time dedicated to day-to-day outreach is necessarily lessened.

RECOMMENDATIONS: OUTREACH AND EMERGENCY SHELTERS

It appears that many of the challenges in meeting the needs of the homeless/street-involved population are associated with communication and role definition problems amongst the different workers. Solutions may therefore be fairly easy to enact, provided there is some flexibility in service policies to do so.

CR.i. **Build collaborative practices and improved integration between shelter, outreach, and transitional workers to ensure seamless service provision and information sharing.** Improved integration should yield fairly immediate benefits, since there will be an improved capacity to track the needs, service usage, and progress of individuals in a more systematic way.

CR.ii. **Revisit the policies governing emergency shelters and case management roles and responsibilities of OW caseworkers and shelter staff.** Current policies clearly articulate the planning and referral role of shelter staff in a collaborative team-based model with Ontario Works. Current practices represent a misunderstanding of policies among shelter staff that are creating referral barriers.

CR.iii. **Explore the provision of primary care and specialized mental health and addictions services within the shelters themselves**. Primary care, in particular, is a consistent "foot in the door" to engage individuals in service, and most people experiencing homelessness lack a primary care connection. Establishing a primary care relationship can then lead to needed treatment and support regarding mental health and addictions.

CR.iv. **Explore the establishment of a wet shelter in Peel Region**, to accommodate individuals with alcohol addictions.

CR.v. **Introduce cultural competence and anti-oppression training for front-line workers** and **consider the development of family-level support interventions** to accommodate cultural preferences. **Ensure diversity of these service providers is reflective of the community**.

MAP D – CASE MANAGEMENT

Case management is core to community-based mental health service. It provides an intensive, one-on-one, goal-oriented approach to recovery and well-being, while continually strengthening service connections and community-focused relationships for individuals with serious mental illness. It should be noted that many individuals in need of mental health supports, including those at heightened risk of crisis, may not qualify for case management, which targets individuals diagnosed (or diagnosable) with a major mental illness (e.g., bipolar disorder, schizophrenia, major depression).

Over the years, case management as a service has splintered into numerous specialized areas. In Peel Region, depending on the organization in question, case management may be divided into “long-term” or “short-term”. Short-term case management has been introduced in many communities as a way to meet the needs of individuals who have some specific areas where they need support, but also who have personal resources at hand to address the issues, and who are unlikely to need prolonged support. Sub-areas of case management may be focused on individuals in conflict with the law (“justice” case management), or in relation to dual diagnosis or concurrent disorders. Case management may also be specialized for seniors or linked more specifically to supportive housing.

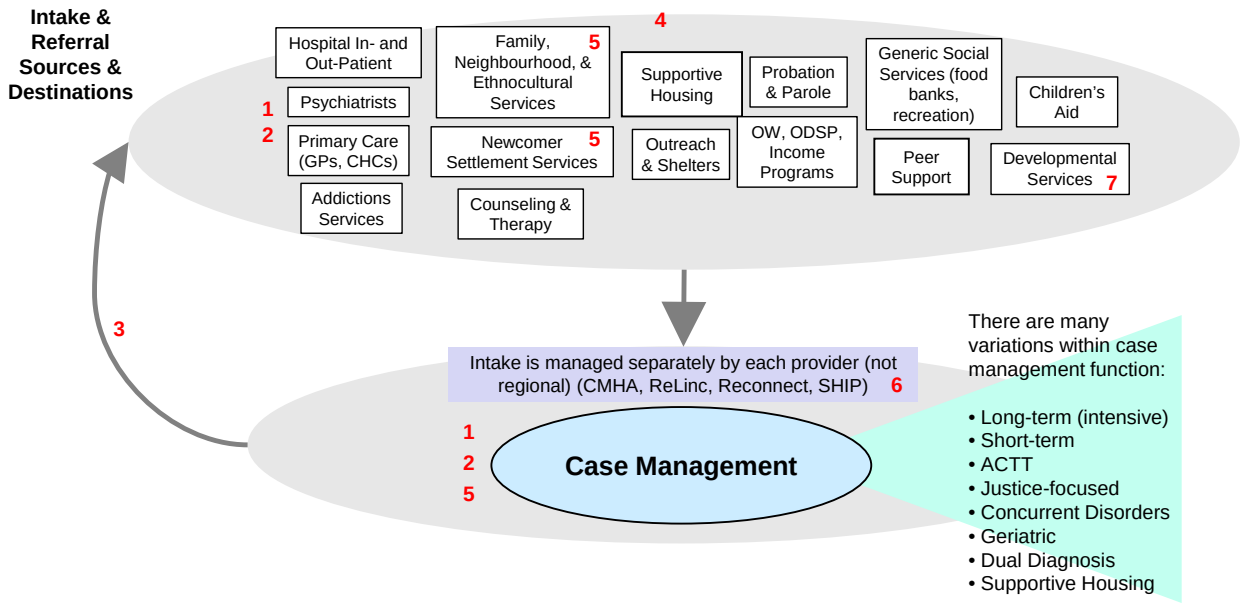
Assertive Community Treatment Teams (ACTT) represent a high intensity, multi-disciplinary team based approach to meeting the needs of individuals with highly complex needs. ACTT is a different service than case management due to the team-based approach and the much higher level of need. In Ontario, it is a separately funded service with its own service delivery standards. That said, ACTT fulfils the same function as case management and shares the same goals of person-centred mental health recovery. ACTT was not a specific focus in this review and is nominally included under the broader case management category of service.

In Peel, formal case management services are provided by CMHA, Trillium Health Partners (through ReLinc at Brampton Civic Hospital), Reconnect Mental Health Partners, and Supportive Housing in Peel. Managers and front-line workers representing these organizations participated in key informant interviews or a focus group.

In Peel Region, case management is delivered by the above organizations based on predetermined geographical boundaries. The full region is covered with very little geographical overlap and duplication. Each organization has its own intake processes and infrastructure. All the major case management providers are large multi-service organizations with many different programs, supports, and locations and each one has its own dedicated centralized intake. The geographic divisions of the service area are helpful in this sense – if there was significant geographic overlap, there would likely be corresponding navigation challenges to manage, as it would be unclear which organization should be accessed for essentially the same service.

Individuals are connected to each organization's central intake through a wide range of referral sources, as displayed in Map D, below.

Map D – Case Management Services



Since case management is a core community based service area for mental health, it is a very common referral destination across the entire social service system. The main referral sources into case management are listed at the top of Map D. Conversely, a main function of case management is to link individuals to other services. While there may be some minor exceptions, the referral destinations of case management are just as likely to be the same as the referral sources.

CHALLENGES IN THE SYSTEM: CASE MANAGEMENT SERVICES

There were a number of systemic challenges identified by front-line works and management.

D.1. **In the Region, wait lists to access case management are lengthy for most organizations and programs.** Wait times can be particularly long (a year or more) and wait times for supportive housing can be even longer. Psychiatry is particularly difficult to access due to wait times. Wait times for counselling, therapy, and outpatient programs vary and are a bit more accessible on average, but still viewed as problematic.

D.2. Wait list problems in D.1. are in reference to generic versions of services. In addition, **there are serious gaps in the system in providing culturally and linguistically appropriate psychiatry and case management**.

D.3. As mentioned in Map C, **there are large variations in service eligibility requirements, exclusionary criteria, and narrow intake processes**. This makes it difficult for case management services to refer to other services and supports. Some organizations have low risk tolerances, especially in relation to individuals who have had contact with the law. Conflict with the law is commonplace for individuals using case management services, making it difficult to arrange services for a considerable proportion of supported individuals.

> "Another area where there is obviously a large divide is the criminal justice system, in the court system. We see individuals who come out with numerous needs, criminal recidivism, getting them stabilized in the community, whether still on bail, waiting for trial, whatever the efforts, they have that judicial connection. To get supports, between short-term and long-term there's a lot of barriers pertaining to risk and need that hinder services quite frequently through that population."
> Case Manager

D.4. Case managers identified **a general need for less intensive community based supports** (peer support, day programs, recreation, group programs, etc.) to offset wait lists for intensive supports, and to meet the needs of individuals who may not need intensive case management, but nonetheless need some level of support.

D.5. Case management **needs to improve in relation to cultural sensitivity, language appropriateness, and community embeddedness**. This observation is generally applicable to most mental health services that are delivered by "mainstream"[18] mental health organizations. **Consistent connections between case management services and ethnocultural services are lacking.**

There have been some in-roads in this area, where case managers hailing from specific cultural backgrounds have been hired and strategically linked to community-specific services and events.

> We've had therapists that we brought on that were very aware of the cultural knowledge, of the language, and were connecting with people in their own culture. They were more likely to be successful because people felt understood and they were trusting. They had built that therapeutic rapport on neutral ground, and they started to be able to work with the bigger system more comfortable and competently.
> Case Manager

D.6. Centralized intake for each organization is a strength *within* each organization, as the organizations in question provide numerous, interconnected services. However, a lack of *regionally centralized intake* means that case

[18] The term "mainstream services" was used by many respondents to reference organizations that are not culturally-specific, and that deliver services from a western, individualized perspective that assumes a shared conception of "mental illness" and "mental health". The term was also contested by providers who feel that it suggests that these services cannot meet the needs of minority groups.

management is not a “regional program”, even though it is funded in this way. Case management looks different depending on the organization, because each organization has different access to other types of programs that they deliver. Where a person lives will largely determine the array of supports that are available through the case management service.

D.7. A specific gap relates to individuals with dual diagnosis. Developmental services for children are quite comprehensive in Peel; however, these services are lost when individuals transition to adulthood. Case management sometimes struggles to support individuals in this transition. It is especially challenging when an individual did not obtain a diagnosis as a child, as the assessment procedures for adults are much harder to access. Finally, individuals who do not quite qualify for developmental services (due to IQ cut-offs) but are “on the cusp” require much more intensive supports than what might be available through case management.

RECOMMENDATIONS: CASE MANAGEMENT SERVICES

Challenges related to case management in Peel are a consequence of inadequate resources and a diminished capacity to respond. There are long wait lists to get the service; meanwhile, other programs and services in the community have low risk tolerance and narrow criteria for eligibility. There is potential confusion over the many different types and subtypes of specialized case management that are available. Finally, there is a general difficulty in reaching people from diverse cultural backgrounds.

DR.i. Case management is designed (and designated by provincial policy) as an intensive service for people with serious mental illness. A significant gap is a lack of service options for individuals with less intensive needs. **The system, in collaboration, should create a suite of ongoing, lower intensity services focusing on mental health education, support, and recreation (for groups, with opportunities for individual consultation).** Such services would be preventive and would also reduce wait list pressures for case management and other existing services. Different cultural groups may also be more receptive to such community based services, which could be construed in less stigmatizing ways (we elaborate this point in later sections).

DR.ii. **If case management is to be accessible to different ethnocultural groups, staff must be from the groups in question and services must be embedded in places that individuals congregate (faith group locations, culturally-specific service agencies).** There has been some success in introducing case management services into different ethnocultural groups, as long as it is done so slowly and in the home language, after trust has been built.[19]

[19] For example, see http://www.healthcouncilcanada.ca/rpt_det.php?id=258

A strong caveat, however, is that the case management service modality – individualized, and explicitly referencing mental illness – may be incompatible with certain groups, even if the worker shares the language and culture. Case management is premised on the notion of self-identification, awareness, and recovery – such a schema will be foreign to some individuals who do not recognize and understand the "mental illness concept".

DR.iii. The system needs to collectively come to some conclusions as to whether case management is a "regional program". While it is funded this way in a superficial sense (i.e., to the extent that the same funding is going to this service type) it is delivered in different ways by the main agencies. **If case management is going to be understood as a regional program, the same essential service should be available in all areas of Peel Region. This includes the opportunity to access the same adjunct services that are currently provided by the different organizations to their own case management case loads, but not others.** For example, individuals who receive case management from a hospital may have better access to other services, such as allied health and psychiatry. Such services should be available to all individuals, if it is truly a regional program.

It is often suggested that intake for a core, provincially funded service be centralized across all local service providers. However, the main providing organizations in Peel are large, multi-service in character, and all have made great efforts to centralize their own intake across case management and other programs. Because there are some fairly clear geographic boundaries of organizational catchment, common problems of service navigation are lessened. Both local LHINs are continuing to work with organizations to examine coordinated intake options and opportunities. We will return to this discussion in a Section G.

MAP E – FAMILY, NEIGHBOURHOOD, AND ETHNOCULTURAL SERVICES

An important access point to mental health and other social services are a range of family, neighbourhood, and ethnocultural service organizations. These organizations provide a range of services to families, and may often include supports that focus on mental health and well-being. Because they are not "formal health services", they are often neglected when considering navigation and access issues in relation to mental health and addictions. Nonetheless, they serve as key access points to families and individuals who may be struggling. In Peel Region, these organizations are often the first point of contact for many residents.

It is also the case that these community organizations have made it a firm priority to meet the needs of the diverse range of ethnocultural groups in the region. They aspire to provide culturally and linguistically sensitive and accessible services to many different populations. This includes people who have been in Peel for many generations and those who have newly arrived in Canada. Some organizations identify with specific communities (e.g., Chinese, Punjabi, Black communities).

> "We know that newcomers come very healthy to our centres. Within one year, two years, three years, depends on the coping system or resiliency, they will experience mental health difficulties, and in very different ways, from stress, precarious employment, poverty, not coping with the kids, and the gap between parents and children – there are so many elements that affect their mental health in a family. What I always really wanted on my wish list is prevention, not intervention, because it's not my job to do intervention. The hospitals and others professional agencies, they can do it; but we should really have some ability and services to prevent illness from happening."
> Settlement Agency Representative

As mentioned, a specific goal of this project was to provide a greater understanding of the navigation and access barriers to individuals from diverse ethnocultural backgrounds, with specific attention to South Asian, Chinese, and Black Communities. This goal prompted the inclusion of family, neighbourhood, and newcomer settlement service organizations that have health and wellness as part of their broad mandate.[20] We held a cross-organizational focus group of front-line staff and conducted a number of key informant interviews with community and organizational leaders who represent the groups of interest.

We also would like to point out that "family services and supports" are a core component of any effective mental health system. The role of families as sources of social and emotional support is foundational. For example, in CMHA's *Framework for Support*, family and friends are a main pillar of support within the Community Resource Base, alongside self-help, mental health services, and generic community services and groups. The present map, however, is more specifically concerned with how family, neighbourhood, and ethnocultural organizations work to improve the mental health and wellness of different ethnocultural groups that may otherwise be detached from typical mental health services. Family support, in a more generic sense, was not a specific focus of this work. It was somewhat concerning that the role and influence of family members often went largely unmentioned when discussing the services and practices of many organizations in the system. A lack of information regarding family support in Peel Region is a limitation of this report and a potential gap in the system.

In Map E, the organizations of interest vary in the types of services that they provide. Many of these organizations provide immigrant settlement services and focus on the basic and urgent needs of the people they see, such as income and employment support, education, ESL, housing, food security, health and wellness, and the provision of information regarding the Canadian context and life in Peel Region. Direct

[20] Faith groups are another example of where newcomers will make initial contact with community and, potentially, to other services.

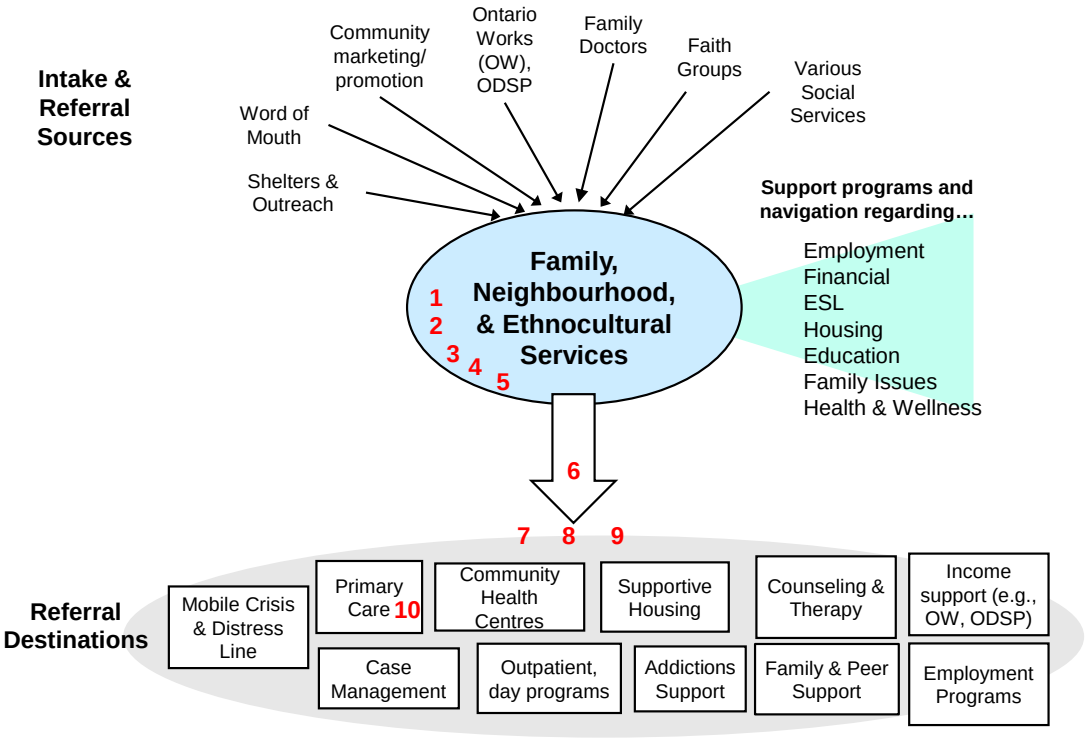
concerns with mental health supports are viewed as secondary, yet extremely important. The general rationale is that urgent needs provoke stress that negatively affects well-being; addressing life needs first helps alleviate or prevent crisis. That said, many workers consistently see a need for more direct mental health support, such as counsellors, therapists, and access to psychiatry. Additionally, family, neighbourhood, and ethnocultural services focus their programming on health and well-being and provide a range of group programs, individual counselling, family therapy, and other supports, in addition to the range of settlement services and community referrals.

> "The community does not seem to understand, and in fact oftentimes there is a hostility by the caregivers, that somehow we are unnecessarily labeling this person. The symptoms are not that bad, according to them. He or she is just spoiled or just needed to be educated, or has a difficult personality. So now we have in fact two parties, one client and one caregiver, actually not understanding the illness and thereby not following the treatment plan as devised by the psychiatrist or other healthcare professionals.
>
> Even if the caregiver or the client accepts that there is a mental health issue, now the problem becomes that they don't want anybody to know that they are coming for help, they do not want under any circumstances any of their family members or relatives to find out that they have a mental health problem because then their children will not get married because of the stigma."
> - Health Services Representative

These organizations tend to provide services to families who may not be experiencing serious mental illness, but who are potentially at risk for mental health crisis, family dysfunction or breakdown. Individuals may use services in order to find employment, yet community workers routinely see signs of stress, anxiety and depression. Many newcomers, for example, have unresolved trauma from their home country and immigration experience, or are struggling with intergenerational family conflict and a values clash with Canadian customs and expectations. Poverty and isolation also contribute to mental health difficulties.

Map E presents the referral sources and destinations for family, neighbourhood, and ethnocultural services. Referral sources include shelters and outreach, word of mouth in the community, media/marketing, OW/ODSP, general physicians, faith groups, and a range of social services. Referral destinations are quite similar to the referral sources/destinations of case management, in Map D.

Map E – Family, Neighbourhood, and Ethnocultural Services



CHALLENGES IN THE SYSTEM: FAMILY, NEIGHBOURHOOD, AND ETHNOCULTURAL SERVICES

E.1. **Respondents emphasized that services are in great need of mental health specific funding.** With one or two exceptions, these types of organizations do not receive mental health funding from the Ministry of Health and therefore must find other funding sources to meet this need. Respondents identified a funding need for mental health counsellors, especially those who can speak the home language of prominent linguistic groups in the region.

> "We're not allowed to leave our offices. Those types of barriers are systemic, but they're not about the client. We don't go out, travel with the clients."
> Settlement Agency Staff

E.2. The primary funder of settlement services is Citizen and Immigration Canada (CIC). In regards to mental health, **CIC focuses its funding primarily on service referral rather than on direct service provision, such as on mental health supports.** There is a potential opportunity for CIC to more directly address mental health promotion and illness prevention with strategic funding in these areas.

E.3. For some agencies, **there are funding accountability pressures to maximize "the number of people seen".** Such pressures discourage in-depth personalized support in favour of increasing the number of appointments.

> [Social Service Agency] have a huge list, and it's just not helping actually. They have a referral list and then we always refer them and make appointment for the clients to go there. But tell you the truth that this referral takes six months, eight months. They have a huge list and it's just not helping
> Settlement Agency Representative

E.4. Some respondents felt their **service hours were inflexible and inaccessible to many potential users.**

E.5. Some **funding sources (e.g., CIC) do not fund settlement programs and services for refugees or non-status newcomers**. Alternative funding must be acquired to meet the needs of this subgroup.

E.6. Workers report a need for an accompaniment role to ensure that referrals are followed through and to support and advocate for access. However, **offsite accompaniment is discouraged or contrary to agency policy. Even if accompaniment were possible, the time to do so would be very limited** (see E.3., above).

E.7. Many cultures attach very strong stigma and shame to mental illness, which leads to strong resistance to using services. **Mental health services are not understood as a form of health promotion and prevention but solely for people "who are crazy".** Some cultural groups may not possess a "schema" for mental illness; western notions of mental illness may not translate well in other cultural perspectives.

E.8. There are **long wait lists** for many mental health and social services.

E.9. From the perspective of front-line workers, mental health and other **social services, when accessed, are useful and helpful to a point, but sometimes lack cultural sensitivity and language accessibility.** There is variability in the region, and respondents reported that there are also many examples where cultural and linguistic accessibility are good.

E.10. Many people use walk-in medical clinic services for primary care needs. **Given that general physicians are viewed as a main referral source to mental health services, relying on walk-in clinics for this function is problematic**.

E.11. **Respondents identified a need for more individualized therapy. However, therapy (e.g., from a psychologist) is rarely subsidized and costs money for people to access.** Sliding scales are often available, but payment is still a disincentive.

RECOMMENDATIONS: IMPROVING MENTAL HEALTH SERVICE ACCESS OF ETHNOCULTURALLY DIVERSE GROUPS IN PEEL

This section provides a set of recommendations in reference to family, neighbourhood, and ethnocultural services, but also in relation to mental health service access of people from diverse ethnocultural groups in general. These recommendations pull from the findings across all the interviews, focus groups, and subsequent mapping analyses.

The problem of meeting the needs of diverse ethnocultural groups is very complex and may sometimes seem intractable. We heard a consistent conundrum from many of the respondents – members of some cultural groups are trepidatious in accessing mental health services because of language barriers (real or perceived) and cultural insensitivity. On the other hand, these same individuals may be equally leery of accessing culturally-specific services due to feelings of stigma, shame, and intense worry of others in their community finding out. One respondent provided an example of how adults may hide their own or their spouse's mental illness because, if it were discovered, their children would be unlikely to get married due to family stigma. The shame associated with mental illness runs deep in many cultures. An additional exacerbating point is that mental illness as a concept is unfamiliar and strange to people from some cultures. People with mental health difficulties may be blamed for their own struggles.

It is unsurprising then, that established, conventional mental health organizations are concerned that they are not reaching many people who may need help. One respondent noted that even when case managers were from the culture and fully embedded in community events in every way they could think of, service uptake was still minimal. The problem of low access is unlikely to be solved by individual organizations diversifying their workforce and language capacity, or by pursuing cultural sensitivity training. These elements are most certainly important for the individuals who do avail themselves of the service. However, the fact that a mental health organization is culturally-sensitive will still not attract the people who are currently not engaging in their services, if the service itself is culturally unfamiliar at a fundamental level.

> Re: Mental health education and outreach: We take them for one whole day. Our approach, from even how we make the client sit down, how we give them a cup of tea, how do we talk about their family and experiences of coming to Canada. Ours is a very informal way of collecting information from the client, whereas within the North American context, we are very formal so we bring them in the counseling room, and we ask certain assessment questions, and I think that our community members become very uncomfortable with the formal part.
> Health Services Representative (South Asian focus)

Some individuals in this project recommended that more culturally appropriate counseling services were needed at these organizations. Individual and family counseling is an important component of a good system

and will carry some benefit. On its own however, it is not the solution to those culturally systemic barriers that prevent individuals from identifying their struggles and accessing help.

ER.i. **We recommend a concentrated community development process that is led by community leaders.** It is argued that the only way to fully engage the community is to develop ways for the community to own and reframe the mental health issues. The stigma must be addressed first, before there is hope for general participation in services. **Mental health struggles need to be reframed in non-threatening, familiar ways for individuals**. For example, stress and anxiety can be reframed as "worrying about my job". Family counselling can be reframed as "addressing family arguments", and so on. Whatever the reframing is, it needs to be developed by community and faith leaders. The focus should be on education, awareness, and mutual support (again, in familiar and accessible terms). More open attitudes and dialogue need to be modelled by community leaders.

A ***Mental Health Focused Community Development Process*** could have the following ingredients:

a. Family, neighbourhood, and ethnocultural service organizations build outreach capacity (e.g., "community outreach workers" from the home community) to help develop the community development process.
b. These organizations create connections with faith leaders to discuss current mental health issues in the community and strategies to address them.
c. Community development projects consult with mental health organizations to build some core messages of mental health promotion. These messages (e.g., in the form of brief educational sessions) are translated by volunteers and made culturally sensitive and engaging.
d. Community outreach workers conduct educational sessions at gathering places (faith groups, other community groups and gatherings) that are specific to identified problems with living. For example:
    - *Dealing with family conflict*
    - *Financial stress and worry*
    - *Communicating better with your spouse*
    - *Becoming more active in your community*
    - *Local social services you should know about.*
    - *Mental health: What is it?*
    - *Your kids growing up in Canada*

    These are merely placeholder ideas. Actual content will need to be developed in consultation with community leaders.
e. Outreach workers attract community members to the lead organizations for ongoing educational groups that focus on mental health issues. The goal is to establish active, highly visible leadership that brings together community members to define and address their own issues of mental health and

wellness. The organization can connect people to the larger community; and the large community can become connected to the organization.

f. Partner mental health agencies continue to provide consultation and support to the community development process and resulting educational forums and sessions. Over time, individuals can become familiar with the range of mental health services available and can become connected to a broader range of services within a more familiar cultural milieu.

A community development process needs to be culturally specific and strategies will look slightly different depending on the community in question. This is where United Way of Peel Region's South Asian, Chinese, and Black Councils can play an important role. The specific stakeholders involved in a community development strategy will need to be identified; recruitment and organizing strategies will vary based on the more detailed understanding of the community in question – where people gather, who the leaders are, who has positions of authority and influence, and so on.

ER.ii. **Mental health-focused support needs to expand beyond an individualized, treatment and therapy focus to include holistic, family level health and healing.** Collectivist (and patriarchal) cultures will tend to respond to family level interventions rather than individual approaches. The system needs to accommodate this cultural view and somehow reconcile it with individualistic policies regarding privacy.

Realization of the above actions will be a slow process, but perhaps the most important and impactful resource community members have (and may be willing to access) is each other. Once community participation and ownership increases, multi-organizational partnerships can begin to insert themselves into the dialogue and begin to work with individuals who need help and show an interest in the service.

The question becomes, "Who takes the lead?" It is clear that culturally-specific agencies and/or agencies that focus on newcomers and immigrants and racialized populations must play a leadership role, in collaboration with faith groups and other forms of community leadership. A dilemma associated with this general recommendation may revolve around funding and limitations of mandate. Currently the majority of funding is for newcomer settlement organizations' settlement support and referral and does not come (and likely *cannot* come) from the Ministry of Health.

ER.iii. **A mental health community development process will require core, sustained funding for there to be a meaningful impact.** Family, neighbourhood, and ethnocultural services need to be able to expand their services to encompass a more holistic vision of health promotion and well-being. This will require strategic, collaborative funding from a range of sources, including federal agencies, such as CIC.

A final point to address is the extent to which South Asian, Chinese, and Black communities experience system barriers differently. It is perhaps the case that some differences would be uncovered with a deeper methodology and analysis (and in fact, one would expect variation within these large ethnocultural categories). But based on the general goals of the project, we found that the most common barriers were very much shared.

F. CALEDON: THE RURAL CONTEXT IN PEEL

In initial consultations with stakeholders from Caledon, the northerly and primarily rural area of Peel region, it was decided that a cross-sectoral, cross-organizational focus group would be most useful to gather system information. It is well known that services are lacking in Caledon. For example, there is not a "system of case management" in Caledon that needs specific analysis; rather, there are examples of case managers from organizations in urban Peel doing outreach in the rural areas. It made more sense to bring together multiple organizations to discuss gaps, challenges, and opportunities in the Caledon context.

A group facilitation was conducted with several service providers to understand the local system in Caledon. Referrals into and out of the participating organizations were discussed together. The rural context means that organizations know each other quite well and refer back and forth as necessary, with the general acknowledgement that there are many gaps. There are not clear "system components" in Caledon, but rather a small number of organizations filling particular service niches. For this reason, it did not make sense to develop a system map for Caledon, and instead the report identifies common challenges, gaps, and opportunities.

CHALLENGES IN THE SYSTEM: THE RURAL CONTEXT IN CALEDON

A number of challenges and gaps were identified by respondents, and are typical of many rural contexts in Ontario. Before discussing these challenges, there are few factors to consider. First, Caledon is growing. What is currently considered a rural context is becoming a developed suburb of Peel Region, with the Town of Caledon and Bolton both experiencing growth. The service needs for Caledon will obviously need to correspond to population increases. Caledon can also be expected to grow in its diversity, with growing numbers of people from many ethnocultural backgrounds settling in the area.

Second, some collaborative advancements have been made in Bolton where a number of organizations are centrally-located in a downtown service hub. Caledon Community Services is an anchor tenant and a multi-service organization that provides a range of programs for newcomers, seniors, youth, and families. Services include employment support, food security, shelter and housing support, income security, and others. Co-location of this type, especially in rural context where services are less available, provides a range of opportunities to respond to community needs.

Participants identified a number of challenges in Caledon:

F.1. As mentioned, **there is a serious lack of services. Of the services that do exist, capacity is stretched.** There are very limited options for clinical services, especially in relation to crisis intervention, assessment, concurrent disorders, and primary care.

F.2. **Mobile Crisis has difficulty responding to calls in Caledon**. Response times are slow.

F.3. The closest hospital is in Orangeville (Headwaters Health Centre), which is not a Schedule 1 facility. **Local residents have to travel much further to receive hospital-based emergency mental health services.**

> "I think the way for Caledon to go is to use what exists, but also to have that untrained, peer support group that is constant, weekly at the exchange over dinner, and have people get together once a week, peer facilitated, peer led."
> Caledon social services focus group

F.4. **Transportation options in the region are extremely poor. Furthermore, residents are often intimidated and unwilling to travel to Brampton or other urban centres to access available services.** Travel to Brampton is often the only option for assessments, which are required for services in Caledon.

F.5. Most people in Caledon have a family physician. However, **there is concern that many physicians are unable to manage mental health issues and/or appropriately refer to other services in Caledon or the region.**

F.6. A small town context can lead to **worries of stigma and unwanted disclosure**, especially when accessing services in a central town location.

RECOMMENDATIONS: CALEDON AND THE RURAL CONTEXT IN PEEL

In Caledon, there is a need to carve out services that are maximally accessible as a large rural area with small population. As described, social and health service gaps are severe. In this context, we make the following recommendations:

FR.i. Contact with people in need should be mobile and flexible for people who may lack transportation. This does not mean making *all* service types mobile; rather it means making the first (and ongoing) point of contact as mobile as possible. **Family Health Teams may be an effective way to deliver comprehensive primary and allied health care services, including in rural settings.** Family Health Teams have already been established in other rural settings in Ontario in order to deliver a range of services. The use of Ontario Telemedicine (OTM) is also an option for teams to gain medical advice and resources that are not locally available. **The use of Family Health Teams to serve as primary care providers for mental health care should be explored.**

FR.ii. **Continue to co-locate services so that when people have to travel, they are going to the same place to get multiple needs met and can become more easily familiar with what is available**. The grouping of services anchored by Caledon Community Services in Bolton is a great example.

Family Health Teams (see FR.i.) would formally tie into service hubs. Services in Brampton need to build a more solid presence in Caledon, via consistent co-location and ongoing collaborative efforts.

FR.iii. Caledon could benefit from more peer support. It is offered by some local organizations but is otherwise limited. **Peer support is recommended as a vehicle for support in Caledon** (acknowledging it is beneficial in all settings)**; it is needs and citizen-driven, and it can located in many different types of locations and environments. Because it is inexpensive and largely self-sustaining, and it is not complicated to start up.** Citizens in Caledon who are in need are isolated. Peer support provides a safe environment to exchange informal support and start to connect to the services that are available. Outreach should commence immediately to begin to build peer groups.

FR.iv. The recommendations above need dedicated funding. **Funding should focus on Family Health Teams (or more mobile primary care) and inter-organizational partnerships that promote integration and coordination of service.**

G. FIRST CONNECTIONS TO THE SYSTEM

Early on in this project, it was suggested that a useful product would be a comprehensive service inventory of what supports, services, and programs are available in the Region. Further discussion led to a recognition that similar resources already exist. In fact, there are a number of examples:

- CMHA Peel created a searchable online database of mental health services in Peel and surrounding area.
- Catholic Crosscultural Services led the construction of a searchable online directory of mental health services in Peel Region. (http://mentalhealthpeel.ca)
- Citizen and Immigration Canada and Region of Peel provide the Peel Immigrant Web Portal, a centralized resource and directory for newcomers. (http://immigrationpeel.ca).
- The Region of Peel delivers and maintains the 2-1-1 service, which provides information on local community, social, health, and government programs. (http://peelregion.ca/corpserv/211.htm).
- United Way of Peel Region has published hardcopy directories of services and programs in multiple languages.
- Connex Ontario provides health services information in the province, including mental health, drug/alcohol, and gambling helplines. (http://connexontario.ca)
- Health Info (HI) is a community resource site for Mississauga providing resources and service information for elderly residents and caregivers. (http://consumerhealthinfo.ca)

In addition to these compiled online resources, many of the larger mental health and social service organizations, as well as municipal government, have their own menus of internal services and contact information to get connected. While the system seeks to create an environment of “no wrong door”, there appear to be too many doors, online and on foot.

While it was not the goal of this project to create a service inventory, access and navigation obviously relies on these types of resources. Currently there is considerable duplication. The larger mental health organizations have well-developed intake processes for their internal programs, of which there are many. They also have fairly clear catchment boundaries between them. However, there are also many smaller and specialized organizations and programs. Beyond the mental health-specific organizations, there are even more social service organizations that are nonetheless highly relevant to mental health and wellness.

What is needed is a convenient way for all residents to initially get connected to the services they need. In other words, to create a system where there are many ways to get to the same place – a single number and website that can appropriately refer people to the service/support that makes the most sense given their presenting problem, location, personal context, and so on.

GR.i. **A centralized body should be made responsible for appropriate referral to mental health and other services, accessible online and by phone**. This body should be directly funded and resourced to continually maintain program and resource information in the region. It should be well-publicized and marketed by all partners across the system and related sectors. *211 Peel* may be an option. **It is also recommended that this component remain consistent across the two LHINs**

This issue of service access is actually much more complex than the issue of "first contact" just described. Access does in fact refer to first contact, but also includes screening and eligibility, intake (which could be centralized regionally or left to each organization), assessment, wait list management, transitions, and ultimately direct service delivery. The fact that Peel Region is serviced by two separate LHINs adds an additional layer of complexity. Currently the Central West LHIN has begun to articulate a preferred model of integrated system access to improve the access functions in the region. There are recent efforts to implement this approach in collaboration with the Mississauga Halton LHIN.

PRIORITY RECOMMENDATIONS AND NEXT STEPS

This project has identified many different system challenges in Peel and has generated numerous recommendations to address them. Many recommendations are complex, resource intensive and involve multiple organizations and sectors. A major recommendation that applies to the Peel Region community as a whole relates to the need to better understand rates of service access of different ethnocultural groups. Local organizations reported that their client populations are diverse and represent the range of cultural and linguistic backgrounds in Peel. However, key informants also felt that there could be many residents in need who are not using and accessing services, due to many of the barriers described in this report. There is currently little in the way of demographic data that can describe population level details of service access. It might be the case, for example, that certain neighbourhoods have a higher distribution of certain ethnocultural backgrounds and that these residents have lower rates of mental health service access. This type of information would be helpful in targeting outreach and community development efforts.

To conclude this report, we recommend the following:

- Major mental health services and organizations begin to collect information about ethnocultural identity, spoken language, and postal codes, if they do not do so already.
- Map service use in relation to neighbourhoods in Peel; if possible, link service use data to available census/population data.

These recommendations suggest a fairly complex, system-wide research project. It would be beneficial to include multiple service types in such an analysis, including hospital emergency and in-patient services, mobile crisis services, community based mental health services, community health centres, and ethnoculturally-specific services. A collective, systematic approach is needed to ensure consistency in data collection and to facilitate clear linkages to population level data.

United Way of Peel Region will continue its convening role to promote continued dialogue and actions to address the recommendations in this report. There will need to be a multi-stakeholder process to prioritize the recommendations and to attach them to different organizations, partnerships, initiatives, and funding opportunities. For example, United Way Peel is particularly interested in the recommendations associated with access and ethnoculturally diverse communities. In parallel, recommendations associated with hospital-based services may be useful to the work of the Peel Service Collaborative. Other sectors may take pieces of this report and pursue a range of system improvements.

A recommended first step will be to conduct a prioritization session with the larger project advisory committee to decide which recommendations are most actionable and impactful. These priority recommendations will be restated in a report addendum, and will reflect the consensus of the committee.

Following these decisions, community consultations and engagement will continue in order to begin implementation of the recommendations.

APPENDIX A – SUMMARY OF RECOMMENDATIONS

The recommendations from the report have been abridged and consolidated below. Please see page references for full explanation and context.

Map A – Mobile Crisis Intervention (page 17)

AR.i. Enhance the Mobile Crisis/COAST service so that it can be delivered 24/7. Expand reach by adding teams.

AR.ii. Coordinate discharge planning with hospitals to ensure COAST/Mobile Crisis can follow-up with individuals after discharge.

AR.iii. Build dialogue and partnerships between COAST/Mobile Crisis and ethnospecific organizations and faith groups.

Map B – Hospital Emergency, In-Patient and Out-Patient Services (page 21)

BR.i. Hospitals should continue to explore ways to triage and divert individuals in crisis from regular emergency admission pathways.

BR.ii. Develop a discharge planning framework at all four hospital sites. Embed a mental health worker from a community-based organization directly in emergency and in-patient services. A subsequent primary worker after discharge should also be community-based.

BR.iii. Out-patient services should open up referrals from other sources, beyond family doctors and psychiatrists only.

BR.iv. Family doctors need greater access and information for mental health and addictions support. Telepsychiatry via hospitals to support physicians should be expanded region-wide.

BR.v. Peer navigation as a hospital service should be explored.

Map C - Outreach and Emergency Shelters (page 26)

CR.i. Build collaborative practices and improved integration between shelter, outreach, and transitional workers to ensure seamless service provision and information sharing.

CR.ii. Revisit the policies governing emergency shelters and case management roles and responsibilities of OW caseworkers and shelter staff.

CR.iii. Explore the provision of primary care and specialized mental health and addiction services within the shelters themselves.

CR.iv. Explore the establishment of a wet shelter in Peel Region.

CR.v. Introduce cultural competence and anti-oppression training for front-line workers and consider the development of family-level support interventions to accommodate cultural preferences. Ensure diversity of these service providers is reflective of the community.

Map D – Case Management (page 32)

DR.i. The system, in collaboration, should create a suite of ongoing, lower intensity services focusing on mental health education, support, and recreation (for groups, with opportunities for individual consultation).

DR.ii. If case management is to be accessible to different ethnocultural groups, staff must be from the groups in question and services must be embedded in places that individuals congregate (faith group locations, culturally-specific service agencies).

DR.iii. If case management is going to be understood as a regional program, the same essential service should be available in all areas of Peel Region. This includes the opportunity to access the same adjunct services that are currently provided by the different organizations to their own case management case loads, but not others.

Map E – Family, Neighbourhood, and Ethnocultural Services (page 36)

ER.i. We recommend a concentrated mental health community development process that is led by community leaders. Mental health struggles need to be reframed in non-threatening, familiar ways for individuals.

ER.ii. Mental health-focused support needs to expand beyond an individualized, treatment and therapy focus to include holistic, family level health and healing.

ER.iii. A mental health community development process will require core, sustained funding for there to be a meaningful impact.

Map F – Caledon: The Rural Context in Peel (page 44)

FR.i Family Health Teams may be an effective way to deliver comprehensive primary and allied health care services, including in rural settings. The use of Family Health Teams to serve as primary care providers for mental health care should be explored.

FR.ii Continue to co-locate services so that when people have to travel, they are going to the same place to get multiple needs met and can become more easily familiar with what is available.

FR.iii Peer support is recommended as a vehicle for support in Caledon because it is inexpensive, it is needs and citizen-driven, and it can located in many different types of locations and environments.

FR.iv Funding should focus on Family Health Teams (or more mobile primary care) and inter-organizational partnerships that promote integration and coordination of service.

G – First Connections to the System (page 46)

GR.i A centralized body should be made responsible for appropriate referral to mental health and other services, accessible online and by phone. This should remain consistent across the two LHINs.

H – Overall Recommendation (page 48)

HR.i Major mental health services and organizations begin to collect information about ethnocultural identity, spoken language, and postal codes, if they do not do so already.

HR.ii Map service use in relation to neighbourhoods in Peel; if possible, link service use data to available census/population data.

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