1/27/2016

Final report for the “Creative Collaborative Communities” Project

Evaluation of the CCC project and research on the state of the mental health system in Nova Scotia

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Suggested reference (APA): Fenton, L. (2016). *Final report for the “Creative Collaborative Communities” Project: Evaluation of the CCC project and research on the state of the mental health system in Nova Scotia*. Canadian Mental Health Association, Halifax-Dartmouth. Retrieved from http://cmhahaldart.ca/

Acknowledgements

The Creative Collaborative Communities project would not have been possible without the generous support of Canadian Mental Health Association, Halifax-Dartmouth, Canadian Mental Health Association, Colchester/East Hants County, Self-Help Connection, and Dalhousie University. In the true spirit of collaboration these partners donated resources, sat on the advisory, provided advice on logistics and workshop content, and tapped into their personal and professional networks.

Margaret Murray, Canadian Mental Health Association, Halifax-Dartmouth
Beverley Cadham, Canadian Mental Health Association, Halifax-Dartmouth
Dr. Linda Bayers, Self-Help Connection
Susan Henderson, Canadian Mental Health Association, Colchester/East Hants County
Dr. Susan Hutchinson, School of Health and Human Performance, Dalhousie University

Thanks also to all of the hard working project staff without whom Creative Collaborative Communities would not have succeeded!

Brittany Naugler, CTRS
Gerard McNeil, Creative Arts Facilitator
Marta Mahini, Community Connector

Finally, thank you to the Nova Scotia Department of Health and Wellness for their generous support through the Mental Health and Addictions grant program “Enhancing Community Supports”.

List of Recommendations

This report produced a number of recommendations for government and community-based organizations. While they are in the report and the report gives these recommendations context, they are listed here for ease of reference.

Recommendation 1: Support increase in funding for mental health.

Recommendation 2: Increase navigational supports. Continue to support the mental health coalition of Nova Scotia and the annual mental health forum, 211, community helping trees, and provide grants to make information available on the web that details community organizations, who they serve, and the programs they offer.

Recommendation 3: Increase support for community and street navigators (e.g., MOSH and Navigator Street Outreach).

Recommendation 4: Support the creation of partnerships, collaborations, and communication between community organizations and public health workers.

Recommendation 5: Public health workers need to be supported (in job descriptions and work plans) to reach out to community mental health workers by spending time in community organizations.

Recommendation 6: Support interprofessional education for institutional health workers in university curriculum and as post graduate professional development. Include in this education information about the role that community mental health workers play in the wellbeing and recovery of individuals with mental illnesses and include community mental health workers in the 'Interprofessional Health Education' program.

Recommendation 7: 'Schools Plus' has successfully navigated confidentiality policies to offer wrap around services to students in the public school system. Use this success as a model for the mental health system.

Recommendation 8: Emphasize person centred care and wrap around services by having the individual with mental illness and all of the care workers in the room at the same time. This will ensure that the individual is not excluded from the conversation about their own care and that all caregivers can be on the same page.

Recommendation 9: Create a fund that organizations can access for interpretation services.

Recommendation 10: Support mental health professionals to access cultural competency training.

Recommendation 11: Create anti-stigma campaigns around what mental illnesses looks like from an experiential perspective for the general public, for the media, and for mental health workers.

Recommendation 12: The central role that individuals with mental illnesses played in the CCC project was noted as unique and necessary, as often it is the voices of staff in the hospitals and community organizations that are emphasized. Focus groups with end users of hospital services and individuals with mental illnesses living in community would help to inform any person centred changes in the system.

Recommendation 13: Consider a 'stepped care' approach for mental health and mental illness to ensure that individuals with mental illness are able to receive the care they need, when they need it: "stepped care is a system of delivering and monitoring treatments, so that the most effective, yet least resource intensive treatment, is delivered to patients first; only 'stepping up' to intensive/specialist services as clinically required" (http://www.wellbeinginfo.org/Stepped-Care-).

Recommendation 14: Emphasize person centred care by supporting more access to, and more flexibility in, the care people are receiving.

Recommendation 15: Collaboration initiatives for mental health should consider including sectors such as employment, housing, education, and immigration.

Recommendation 16: Provide grants to support community recreation programs at low or no cost for individuals with mental illnesses.

Recommendation 17: The frontline role that libraries play in community mental health was well established in this project. Consider supporting a mental health professional or social worker in community libraries. This is already happening in several major centres in Canada (e.g., Winnipeg, Vancouver, Toronto).

Recommendation 18: Provide support for focus groups or interviews with organizations that take their work to the streets (such as MOSH and Navigator Street Outreach) to document ways to better collaborate among community and institutional mental health services and ways of providing transitional support that emphasizes person centred care.

Recommendation 19: Reinvigorate the clubhouse model.

Recommendation 20: Organizations need to incorporate collaboration efforts into budgets, staff workplans, and job descriptions. Staff need recognized time to connect and network. Each grant proposal written should have support for collaboration (i.e., time, money, and space).

Final report: Introduction

In 2012 the Mental Health Commission of Canada released Canada's first mental health strategy, *Changing Directions, Changing Lives*. The report outlines how, in spite of recommendations for person centred recovery models that emphasize the importance of community support, these community supports for individuals with mental health illness are lacking (Mental Health Commission of Canada, 2012). For example, the Canadian Mental Health and Wellbeing Survey outlines that 21.6% of individuals who met the criteria for an anxiety or mood disorder did not receive needed mental health services (Government of Canada, 2006). Particular to Nova Scotia, there currently exists funded networks of community-based organizations that are designed to increase continuity of care as individuals with mental illness (i.e., anyone experiencing a mental health issue or diagnosed mental health problem) move from mental health services to community, thus increasing the likelihood of successful re integration. These organizations include, but are not limited to, Self-Help Connection, Schizophrenia Society of NS (SSNS), Healthy Minds Co-op, Laing House, Canadian Mental Health Association, IWK (mental health and addictions services), and day treatment and addictions services. There are also networks that are less formally recognized and that do not receive government funding to offer mental health services and supports but play an important frontline role in the lives of individuals with mental illness. These organizations include police, drop in recreation sites, faith based groups, housing support systems, and public libraries (Dieleman, 2014). For example, when individuals with mental illness are discharged to live in their communities without a support plan and with insufficient resources, the police, justice system, and housing support system are often first points of

contact during a mental health crisis. In fact, “police have been referred to as de facto mental health care providers and the front-line extension of the mental health system” (Langille, 2014, p.30). Although no statistics currently exist in Nova Scotia, it is estimated that up to 31% of police dispatches in British Columbia involve an interaction between police and a person in a mental illness crisis (Wilson-Bates, 2008). This puts increased strain on policing systems and unnecessarily places many individuals in a justice system where they don’t belong (Teller, Munetz, Gil, & Ritter, 2006). Researchers, lawmakers, and mental health workers and are calling for increased knowledge sharing, networking, collaboration and coordination between these funded and unfunded networks of support to create better person centred continuity of care as individuals with mental illness transition to, and live in, community (Coleman & Cotton, 2014; Derrick, 2010; Langille, 2014). Fragmented and uncoordinated services and supports due to a lack of knowledge of other services are cited as a major barrier to offering a continuation of care (Dieleman, 2014). Multi organizational and intersectoral collaboration is key: where stakeholders work on complex problems by sharing resources, knowledge, and power to accomplish tenable solutions that cannot be accomplished by working in isolation (Hardy, Lawrence, & Phillips, 2006; Miller & Ahmad, 2000). Particular to Halifax, previous research has shown that effective person-centred care relies heavily on informal knowledge and partnerships or ‘who you know’ (Dieleman, 2014).

Research on barriers to effective collaboration from the fields of social work and child care include such issues as the tension between the organization’s goals, agendas, or hierarchical structure and the needs of the collaborative collective (Hardy et al., 2006). Other barriers include a lack of trust or long standing power struggles among organizations that compete for similar funding (Ranade, 1998), as well as disagreement over interventions

(Salmon, 2004) and the predominance of the medical model as a form of care (Miller & Ahmad, 2000). Facilitators of collaboration include hosting “conversations between people, representing a variety of organizations, around a particular issue” (Hardy et al., 2006, p. 102). In effect, it is conversations that are the building blocks to the action of collaboration. Therefore, processes that enable conversation, build trust, and where knowledge is shared can contribute to ongoing collaborative relationships (Gill, 2014).

The Canadian Mental Health Association, Halifax-Dartmouth branch received a Mental Health and Addictions Community grant funded through the Government of Nova Scotia’s Mental Health and Addictions Strategy “Together We Can” for a “Creative Collaborative Communities” (CCC) project. The mission of this project was to nurture collaboration among funded organizations (i.e., organizations that receive government or other funding to provide services and supports for individuals with mental illnesses) and unfunded organizations (i.e., organizations that receive no government or other funding but play a frontline role). The vision of the project was to better serve individuals with mental illness. In particular, the project aimed to shift practices to person centred care and to cultivate the development of a collaborative community of practice. The funds from this grant were used to facilitate weekly Creative Community leisure based workshops for individuals living with mental illnesses to build skills, confidence, and community engagement. Additionally, funds were used to bring together stakeholders (e.g., mental health services, drop in recreation centres, faith based groups, public libraries and individuals with mental illnesses) in half day events that were held in three cities in Nova Scotia (Halifax, Dartmouth, and Truro) and one full day event that was held in Halifax. At each of the smaller Creative Collaborative Communities (CCC) events, 10 to 20 stakeholders were facilitated through a creative arts based process designed to elicit trust, evoke

conversation, and cultivate the sharing of knowledge and power in order to nurture pre-existing relationships and cultivate new informal knowledge networks. At the second Halifax event, there were over 100 attendees (See Table 1 for organizations and sectors represented at all CCC events).

Table 1. Organizations and sectors represented at the CCC

	Number of participants	Overall Percent
Community mental health organizations	57	49
Mental Health Services	10	9
Other not for profit organizations	10	9
First Voice*	9	8
Universities and Colleges	6	5
Community health organizations	5	4
Disability organizations	4	3
Employment organizations	3	3
Libraries	3	3
Wellness navigator	3	3
Recreation therapists	2	2
Peer support workers	2	2
Social workers	2	2
Community Recreation	1	1
	117	100

*Individuals who identify as having a mental illness

Evaluation of the CCC process

This grant proposal included a stipend for research and evaluation. The evaluation process included the identification of progress markers for all organizations that attended the half-day experiential workshops to assess the impact of the CCC project. Progress markers are graduated and attainable goals and were outlined by the stakeholders that the Creative Collaborative Communities project worked with directly. The process of creating progress markers gave stakeholders a concrete road map of the changes in behaviors, relationships, or actions needed to positively contribute to the project's vision (increased quality of mental well-being for individuals with mental illness and mental health problems) and mission (create a community of practice to support existing and cultivate new collaboration opportunities among mental health stakeholders and support a shift in practice to person centred care). The purpose of creating these goals was not only to set sights on achieving them, but to emphasize the process of creating them. Through this process, people who are passionate about their work had a chance to connect, outline their priorities, and revitalize their sense of purpose. In fact, by the very act of meeting, stakeholders attained some of the priority actions identified: "I think it was nice that we identified things we're already doing, so you don't walk away feeling like 'oh my god it's a huge big initiative, it's never going to happen'. You think, 'oh wait a minute we've already done a number of things just in meeting'" (Interviewee 1). Although the CCC project had an established mission and vision at the outset, the mission was further refined throughout the project to emphasize better support for individuals with mental health problems through a shift in practice to person centred care. Participants in Halifax, Dartmouth, and Truro identified priorities that supported this mission

through changes in knowledge and attitudes, and modifications in practice as a result of these new knowledges and attitudes.

Participants identified the need to support an inventory of programs and resources in both informal and formal ways. Informally, this knowledge sharing can happen by having social time to discuss ideas and support one another. More formally, this can happen by contributing to helping trees, going to speak to each other's groups, and contacting 211 to update their data base. Specifically, a mechanism for communication is necessary such as the creation and maintenance of a listserv, support for monthly meetings, an annual event to bring people together, and providing for a 'third space' that is away from work and home where collaborators, including first voice, can gather. Changes in behavior and attitudes were also identified as necessary by reducing stigma about mental illness and changing attitudes about person centred care in community, within the mental health system, and in systems associated with the social determinants of health (e.g., housing and places of work). Change in relationships and practice included continued active collaboration, not only among community mental health workers, but reaching out to unfunded stakeholders (i.e., those stakeholders that do not receive funding to provide mental health support, but who are front line workers, such as police, libraries, and faith groups), and asking mental health services (e.g. clinicians) to reach out and establish relationships with community mental health workers. Finally all levels of government and all sectors including social workers, individuals with lived experience, and community members need to collaborate to create changes in policy that supports person centred care. Particularly, new policies should reflect:

1) Support for a change in the mental health system to one the emphasizes distress and prevention rather than crisis and reaction

2) Best practices in person centred care for individuals with mental illness

3) Dialogue with supporting sectors such as housing and employment, and

4) Increased funding for transitional support

Reflection upon these progress markers eight weeks after creation indicates that there is increased sharing and exchange of resources not only through connecting individuals with mental illness to resources, but also among partners who were involved in the CCC. One participant states:

> Over the past few months, I've invited six service providers to share their resources and expertise with library staff. Sessions were designed so that presenters were able to tell us what they do and how they can support library staff. These visits gave the staff the opportunity to share their experiences and ask questions about serving people who have mental health challenges. The staff feedback from these sessions was great. They reported that they felt they had a better understanding of the services available, how to refer people to those services and who to call if they need advice (Interviewee 5).

Additionally, the online Dartmouth helping tree has seen new organizations calling with information to be added: “it is becoming a well-known, well utilized resource. This tool has been so widely shared that we recognize that although 211 is established we need to continue to maintain this resource”. New relationships have also been established to address the creation of third places (i.e., those spaces away from work and home) and increase awareness and destigmatize mental health and mental illness.

Participants were also asked to evaluate the creative arts process, where stakeholders engaged with each other in constructive and fun ways. Many noted that it was a different process than many stakeholder meetings, where

> I come out of it after three hours and we’ve been navel gazing for three hours and I just feel very frustrated by that. I felt that allowing people to draw and to collage and those kinds of things, opened people up more to talk about things that they might not have normally spoken about (Interviewee 6).

In one exercise, individuals were asked to draw in silence for one minute and then pass their art to the right; each successive person building on the picture. The impact of sharing this silence together indicated a depth of connection that changed the momentum of the project:

> You know I was really impressed with the profoundness, everyone working in silence, and then the people receiving care [from the group] being able to express how that felt to be part of that, I thought that was moving mountains in terms of the conversation (Interviewee 1).

The creative process facilitated existing relationships and created connections that weren't there before through a process that allowed people to get out of their comfort zone and make honest conversation. The process also allowed individuals to see who would be a good potential collaborator:

> it kind of strips you down naked and then you have to be built back up again by the group...like I think it gets you out of that traditional way of doing things, you know and it just opens the possibilities for all kinds of things to come up in conversation (Interviewee 4).

There was an overwhelming positive response to the use of creativity and arts. By including individuals with mental illness as a part of the process, all stakeholders were able to hear about the impact of mental illness first hand. This had a profound effect on all who participated:

> I can't tell you how much I've talked about the recovery piece that that woman talked about … in fact, it has actually changed our entire focus of our organization. Forget about recovery, that's important, but there's a period at the end of that, let's talk about well-being (Interviewee 7).

The CCC project identified major priorities in supporting individuals with mental illness, including a shift in practice to person centred care, the need to 'fill the gaps' in mental health services, in particular, through transitional support, continued interagency collaboration, and

an emphasis on first voice participation. The objectives of the grant proposal were met by facilitating half day and full day creative process sessions that created a collaborative network of service providers and resources, and through this process increased awareness of services and supports.

Research

The grant proposal also included funds for research. Ten stakeholders who participated in the CCC events were interviewed about the state of the mental health system in Nova Scotia, the changes believed to be necessary to support a shift in practice to person centred care, how to increase continuity of care and support transition from hospital to community, the role of collaboration in these changes, as well as what is working well. First, how participants define collaboration, person centred care and continuity of care is outlined.

Definitions

Collaboration is the sharing of knowledge, resources and power. Often, in order to share power, there has to be permission provided from managers, executive directors, or another person in power. One example of sharing power includes having an equal partnership where both partners are contributing the same amount money or resources, or openly acknowledging other organizations as assets. A "level of collaboration that you can share openly and without hesitation, very generously, that is huge" (Interviewee 1). In order to build relationships where knowledge, resources and power are shared, there has to be trust. Building trust means being committed, learning from each other, being focused on a purpose, and

sharing a common language around this purpose. It also includes being supportive of each other and being willing to experiment, take risks, and try new things. It also means meeting on a regular basis and committing to being a part of an ongoing dialogue. This ongoing dialogue is supported through informal coffee groups and formal meetings in order to create a 'spider web of connections'. Collaboration is often thought as within or between agencies, but the CCC had a different emphasis: "this is what's so brilliant about the CCC…collaboration is also about the people that you are serving within those organizations and in fact, it should center around that" (Interviewee 7). Collaboration for person centred care is about institutional care workers and community workers meeting each other half way and emphasizing the participation of individuals with mental illnesses: "collaboration is when the clinicians leave their offices and they come to our organizations and they participate in meetings" (Interviewee 9).

Person centred care is meeting people where they are at and using a strengths based approach that is informed by cultural competency and harm reduction. In practice, it means that the individual in care should have a say in who is caring for them. They should also know what opportunities for care are available to them and be able to access this care when they need it. Care workers should acknowledge that people's needs are unique and position experiential knowledge first and foremost: "in the system there are people who portray that they are experts or feel that they have more expertise than someone who actually lives it - and that very much disturbs me" (Interviewee 7). As such, person centred care means creating an open, supportive, non-judgmental environment and having appreciative conversations with people, so that they understand that they have strengths. It involves eliminating an 'us versus them' mentality and removing shame from conversations. For example, for an individual who chooses to spend all their money on gambling: "do we get stern and shake our finger and scold

them or do we say 'how do you feel about that?'" (Interviewee 7). Person centred care means creating a circle of care for individuals with mental illnesses and therefore inherently relies on collaboration. For example, dieticians, social workers, family doctors, psychologists, and psychiatrists should all be working together as a team and be on the same page; clinicians need to get out of the office and spend time with non-profits and community.

Continuity of care is a 'whole care plan' that you take back to your community and share with all your care providers including doctors and nurses. Without continuity of care in the transition from hospital to community, people fall through the cracks. In fact, people with serious mental illnesses can be a revolving door from hospital and community and when this happens, the police and involuntary hospital stays are usually involved.

State of the Mental Health System in Nova Scotia

The next section outlines the current state of the mental health system in Nova Scotia and the recommendations that follow. It is clear from the perspective of these interviewees that the health system needs to better support mental health. Although many families and friends want to support loved ones with mental illnesses they are often unable to do this in isolation and without the help of services and supports. Funding mental health is a way of taking care of the community's needs; however, lack of funding is cited as a major barrier to improving mental health care. There is a perception that mental health services is not a priority in the health authority and support programs in the community are seen as accessories whereas psychologists and psychiatrists are seen as core funding priorities. There are many individuals with mental illnesses who do not need to enter the institutionalized mental health system and can be supported in their communities, but these community organizations are

overburdened: “there’s often not enough staff so we’re having to cover for each other…there’s no one else to do it and we all chip in” (Interviewee 6).

Recommendation 1: *Support increases in funding for mental health.*

The mental health system as cited by these interviewees includes a wide variety of government and grant funded services and supports; however, there is much critique as to how well this system is understood:

> if you can call it a system. I think it’s a very piece meal group of both institutional and community-based services and resources with some grassroots, some clinical, a whole range of kinds of supports and initiatives including peer-led initiatives, that are not well coordinated and there’s not a lot of communication between them (Interviewee 4).

Particularly for stakeholders who are not formally recognized as a part of the mental health system, do not receive government funding but are front line workers (e.g., recreation centres, police, faith groups, librarians), there is a more prevalent lack of knowledge around what services and supports exist to support individuals in crisis (e.g., mobile health crisis team) or distress (e.g., 211). Therefore, one of the difficulties with the mental health system is knowing what mental health resources are available and how to navigate them: “if it’s frustrating for me, I can’t even imagine what it must be like for someone trying to navigate the system with no help” (Interviewee 6). Articulating programs could partly be done through website and publicity materials; however, many community based organizations do not have the funds to support this.

Recommendation 2: *Increase navigational supports. Continue to support the mental health coalition of Nova Scotia and the annual mental health forum, 211, community helping trees, and provide grants to make information available on the web that details community organizations, who they serve, and the programs they offer.*

When community organizations are working with individuals living with more severe mental health problems like schizophrenia, schizoaffective disorder, or bipolar disorder they often try to work in conjunction with hospitals; however, this relationship can be very disjointed and uncoordinated. Community organizations want to be part of the solution, but in order to do that they need to be in the loop about how to support individuals with mental illnesses and be able to connect with institutional supports. These organizations don't necessarily need to know what the medications are, but can engage in other ways of supporting clients. One of the biggest critiques is that public mental health workers who are providing transitional support work from institutional offices are not getting out of the office and into community. Mental health care professionals should be out on the streets and in the facilities of their community, connecting with community organizations and clients: we need to "show them that what we do here is good and worthy and actually saves them a lot of money because what we is all frontline" (Interview 6).

> ***Recommendation 3:*** *Increase support for community and street navigators (e.g., MOSH and Navigator Street Outreach).*
>
> ***Recommendation 4:*** *Support the creation of partnerships, collaborations, and communication between community organizations and public health workers.*
>
> ***Recommendation 5:*** *Public health workers need to be supported (in job descriptions and work plans) to reach out to community mental health workers by spending time in community organizations.*

Knowledge of, and communication about, the role that each care person plays in the lives of individuals with mental illness, particularly as they transition from institution to community, is imperative. We have to "understand what we all do and better understand how we all fit together in the puzzle. Understanding and respecting each other's roles and what

barriers and parameters we're all working with, I think that would take us far" (Interviewee 5). While communication of roles is essential and there are some community organizations who have dedicated staff time to developing strong communication with institutional mental health workers, there is also negative perceptions about the work that is done in community:

> you can tell people a hundred times what you do but if they don't want to listen and they've already got a set idea, you know, you're working against mindsets. I often find that whatever I do it's not legitimate enough (Interview 6).

There is an elitism around roles, particularly from the institution (e.g., therapists, hospitals) towards community organizations and therefore these organizations have difficulty legitimizing their professions and work.

> ***Recommendation 6:*** *Support interprofessional education for institutional health workers in university curriculum and as post graduate professional development. Include in this education information about the role that community mental health workers play in the wellbeing and recovery of individuals with mental illnesses and include community mental health workers and individuals with mental illnesses in the 'Interprofessional Health Education' program.*

Confidentiality policies are a huge barrier to person centred care and prohibits collaboration among for example, social workers and therapists, institutional mental health systems, community mental health organizations and unfunded front line organizations who are looking to help clients. For example, when confidentiality policies exist for unfunded organizations, staff have to speak in very broad terms to protect the anonymity of the person they are calling on behalf of, which makes it difficult to get the needed information. Interviewees also noted that confidentiality is often used as an excuse for inaction.

> ***Recommendation 7:*** *'Schools Plus' has successfully navigated confidentiality policies to offer wrap around services to students in the public school system. Use this success as a model for the mental health system.*

> ***Recommendation 8:*** *Emphasize person centred care and wrap around services by having the individual and all of the care workers in the room at the same time so that the*

individual is not excluded from the conversation about their own care and so that all carergivers can be on the same page.

Stakeholders in the mental health system (including government and not for profits) who participated in the CCC were predominately Caucasian. In order to better serve diverse populations, organizations need to assess the cultural competency of their organization and then reach out to diverse populations. For example, one barrier for new immigrants is language but there is often no money in mental health organizations for interpretation.

Recommendation 9: *Create a fund that organizations can access for interpretation services.*

Recommendation 10: *Support mental health professionals to access cultural competency training.*

Unfunded networks play a substantial yet often unrecognized role in the mental health system, including community street workers, faith workers, security guards, emergency services, recreation, police and community police officers. While the justice system is often seen as ill equipped to adequately assess and respond appropriately to individuals with mental illnesses and police are "often seen as the bad guy, community police officers, who are probably trained differently, and get to know the community better" (Interview 2) play a more informed role in mental health care. Stigma informed organizations, media, and an uniformed public play a detrimental role in the treatment of individuals with mental illnesses. When an individual is in crisis, it is important to ask the question: "what is the balance between public safety issues, and a person's dignity and right to live a normal life?" (Interviewee 7).

It is clear that individuals with mental illnesses face stigma. In the general population and within the mental health system there is a lack of knowledge about mental illness and mental health problems. Anti-stigma education should emphasize an experiential perspective;

what does it mean to individuals with mental illnesses to have depression and what forms does it take? We need to fully understand what people are experiencing:

> this is what I loved about the CCC, persons at the center were allowed to speak and that they were able to declare what the conversation was going to be about and have some control over the parameters of that conversation, rather than me speaking up from the side and taking over. And I think that's what we do often, we see the person as ill and that illness equals incapability or incompetence and I think that's so very wrong. Just because I have schizophrenia doesn't mean that I'm completely flawed or completely inadequate. I might have trouble managing certain aspects of my life, but why are we focusing on that and not the other things that I can do so very well (Interviewee 7)?

Service providers in mental health need to work from the philosophy that we all have a lot of things in common but individuals with mental illnesses also have some unique things that need to be addressed. Not only do individuals with mental illnesses face stigma but there is also stigma associated with mental health buildings. Therefore, even if there is increased support for programming, individuals may still have difficulty walking through the door.

> ***Recommendation 11:*** *Create anti-stigma campaigns around what mental illnesses looks like from an experiential perspective for the general public, for the media, and for mental health workers.*

> ***Recommendation 12:*** *The central role that individuals with mental illnesses played in the CCC project was noted as unique and necessary as often it is the voices of staff in the hospitals and community organizations that are emphasized. Focus groups with end users of hospital services and individuals with mental illnesses living in community would help to inform any person centred changes in the system.*

Even though some individuals have multiple diagnosis, some learn how to manage their symptoms well with short and long term medication or coping skills. However, when these individuals relapse, all the connections that they had in the mental health system during crisis are gone (e.g., social worker, psychiatrist, community services, therapist):

> I was doing okay for 10 years, I was coping I should say. Then I had a relapse. I had nobody, there was no connection at all. I had to go down to emergency, go through the short-stay unit, go to the day hospital and that's the only way I got back into the system.

Once in the system, it is difficult to maintain these necessary mental health services; when individuals are considered able to cope on their own, they lose their place in the system. My therapist

> asked the question, 'how are you feeling'? I said that's the worst question you can ask here. She said 'why is that'? I said because if I say very good, you say well she's doing very good, we'll take somebody else on. So now that very good person's got nobody and then she relapses. Then how is she getting back in that circle? She's got to fight, she has to commit herself, say to emergency she's going to commit suicide or whatever, she's going to harm herself to get in that system. Is that fair to that person? (Interviewee 8)

The system also emphasizes more severe mental illnesses, such as schizophrenia, bipolar, and schizoaffective; however, not all individuals need institutional mental health system supports for serious illness, some may just need community support. Some interviewees "wonder if the whole service model for supporting mental health needs to change" (Interview 2) by losing "the rigidity around how things work and really focus in on the patient and listen to them: cause they're really smart and they know what's going on" (interview 3).

> ***Recommendation 13:*** *Consider a 'stepped care' approach for mental health and mental illness to ensure that individuals with mental illness are able to receive the care they need, when they need it: "stepped care is a system of delivering and monitoring treatments, so that the most effective yet least resource intensive, treatment is delivered to patients first; only 'stepping up' to intensive/specialist services as clinically required" (http://www.wellbeinginfo.org/Stepped-Care-).*
>
> ***Recommendation 14:*** *Emphasize person centred care by supporting more access to, and more flexibility in, the care people are receiving.*

Mental illness and mental health are inherently related to the social determinants of health and all solutions should consider these determinants, such as lack of housing and racism, as influencing mental health: "if you come from a war, and you have gone through these things

and then you come here and you keep being prosecuted because of who you are, that is a huge toll for people's mental health" (Interview 10).

> ***Recommendation 15:*** *Collaboration initiatives for mental health should consider including sectors such as employment, housing, education, and immigration.*

Success stories

Although interviewees were critical of the mental health system, they noted several successful initiatives and practices that they felt improved services and supports by emphasizing person centred care and transitional support. For example, the Choice and Partnership approach adapted by the IWK is a good step towards person centred care, as well as community health boards that offer wellness grants and work with community partners to offer low or no cost recreation programs for individuals who live in the geographical area. Many of these named success stories involve transitional support around wellbeing, resilience, and prevention – and from organizations or sectors that are not typically thought of as supporting community mental health. For example, there are many gyms that offer $2 drop in recreation programming for low income earners. As well, libraries are increasingly becoming sites of community gathering and supporting a wide variety of community mental health needs. For example, patrons come to the library to ask for information about mental illnesses either for themselves or a loved one, while other individuals are in distress or crisis and need more immediate attention and referrals and information from library staff. The library also provides programming and information sessions by collaborating with, for example, Healthy Minds (e.g., on topics such as stress at work and eating disorders). Libraries often use community development models, collaborating with the surrounding community on projects, and are reaching out to marginalized populations:

> libraries are becoming more and more that community meeting place. I mean the traditional view of the library was that it was a place to come and read, but more and more we're recognizing that libraries are not that place anymore, although we do need to have quiet spaces. It is a place where collaboration can happen, so it is a place where teens can come and talk about a project that they're working on, or just their life. More and more we're seeing that people are using the library for a variety of different things. So for example, if you're living on the street, and a lot of people with mental health issues sometimes end up in that unfortunate situation, then during the day you may use the library as a safe place to come and just rest. So we have chairs, we have the space, and sometimes that's how it ends up being used (Interviewee 5).

It is not always easy to reconceptualise a space that is traditionally thought of as a quiet space of study:

> how we balance that is a real challenge. One of the barriers is, believe it or not, the traditional concept that people have of a library because there are still so many people who are shocked when they see certain things happening in a library (Interviewee 5).

Recommendation 16: *Provide grants to support community recreation programs at low or no cost for individuals with mental illnesses.*

Recommendation 17: *The frontline role that libraries play in community mental health was well established in this project. Consider supporting a mental health professional or social worker in community libraries. This is already happening in several major centres in Canada (e.g., Winnipeg, Vancouver, Toronto).*

Success stories related to community-based mental health services that emphasize transitional support or person centred care includes but is not limited to Healthy Minds Cooperative, Canadian Mental Health Association, Self-Help Connection, Schizophrenia Society, Laing House, the Clubhouse model, the 211 service that is often used by frontline workers to call for information and as a way to update their own organization's program information for the public, community mental health Helping Trees in paper copy that are distributed throughout the community, Families Matter, the Mobile Crisis Unit, and MOSH. Particularly, MOSH (Mobile Outreach Street Health) has: "learned to meet people where they're at" (Interviewee 1). MOSH is credited with creating a paradigm shift in services. This shift is also reflected in the Navigator

Program, an initiative developed and supported by Downtown Halifax Business Commission (DHBC) and the Spring Garden Area Business Association (SGABA). Started in 2007, Navigator Street Outreach provides homeless and street-involved individuals with support around employment and housing, health, mental health and addictions.

> ***Recommendation 18:*** *Provide support for focus groups or interviews with organizations that take their work to the streets (such as MOSH and Navigator Street Outreach) to document ways to better collaborate among community and institutional mental health services and ways of providing transitional support that emphasizes person centred care.*

> ***Recommendation 19****: Reinvigorate the clubhouse model.*

Community mental health organizations often work from a person centred approach. Providing transitional support means that staff need to spend time getting to know their local resources of support and advocate on behalf of individuals with mental illness:

> often what I'll do is meet with somebody first of all and then work out what their needs are…it's really important for me as the outreach worker to make those connections with people in the community because that spider web of connections helps us to serve our people better. So I do the advocacy stuff and I also do kind of navigational things. When somebody comes and meets me they might say I just don't feel right and I don't know how to connect with mental health services at the hospital, so I can help them with that. Or I have nowhere to live, my housing situation is terrible, I'm couch surfing, at the moment I don't know what to do, so I help connect them with what they need to connect with, whether it's a landlord, or whether it's Income Assistance. I help them with forms, pointing them in the right direction (Interviewee 6).

When organizations become known in the community by having a presence in the hospital system or hosting events in the community, they can begin to engage in non-traditional partnerships. These partnerships are often with willing individuals rather than other organizations, and include those who work in medical shops, pharmacy, or other champions:

> I think there is a heart for it, I think that people do want to collaborate you know. I think when people come into human services, or just this kind of work, or anything where you're serving people, it is innately part of you to do that (Interview 6).

Recommendation 20: *Organizations need to incorporate collaboration efforts into budgets, job descriptions, and staff workplans. Staff need recognized time to connect and network. Each grant proposal written should have support for collaboration (i.e., time, money, and space).*

References

Coleman, T. G., & Cotton, D. (2014). *TEMPO: Police Interactions A report towards improving interactions between police and people living with mental health problems*.

Derrick, A. (2010). *Report of the fatal inquiry into the death of Howard Hyde*.

Dieleman, C. (2014). Mapping Community Capacity: Identifying Existing Community Assets for Supporting People with Mental Health Problems who Have Been Involved with the Criminal Justice System. *Canadian Journal of Community Mental Health, 33*(3), 29-42. doi:10.7870/cjcmh-2014-021

Gill, C. (2014). *Working towards a collaborative approach to training on Intimate Partner Violence*.

Government of Canada. (2006). *The human face of mental health and mental illness in Canada*.

Hardy, C., Lawrence, T. B., & Phillips, N. (2006). Swimming with sharks: creating strategic change through multi-sector collaboration. *International Journal of Strategic Change Management, 1*(1), 96-112.

Langille, J. (2014). When Mental Illness and the Justice System Intersect. *Canadian Nurse, 110*(5), 28-30.

Mental Health Commission of Canada. (2012). *Changing directions, changing lives. Mental health strategy of Canada.*

Miller, C., & Ahmad, Y. (2000). Collaboration and Partnership: An Effective Response to Complexity and Fragmentation or Solution Built on Sand? *The International Journal of Sociology and Social Policy, 20*(5-6), 1-38.

Ranade, W. (1998). *Making sense of multi-agency working.* Sustainable Cities Research Institute.

Salmon, G. (2004). Multi-Agency Collaboration: The Challenges for CAMHS. *Child and Adolescent Mental Health, 9*(4), 156-161. doi:10.1111/j.1475-3588.2004.00099.x

Teller, J., Munetz, M., Gil, K., & Ritter, C. (2006). Crisis intervention team training for police officers responding to mental disturbance calls. *Psychiatric Services, 57*(2), 232–237.

Wilson-Bates, F. (2008). *Lost in translation how a lack of capacity in the mental health system is failing Vancouver's mentally ill and draining police resources*. Vancouver, B.C.]: Vancouver, B.C.: Vancouver Police Dept.