camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

Strategic Plan
2009-2012

WHAT WE HEARD:
SUMMARY OF KEY STAKEHOLDER MESSAGES

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1. INTRODUCTION

We must sail sometimes with the wind and sometimes against it – but we must sail and not drift nor lie at anchor.

Oliver Wendell Holmes

CAMH's Board of Trustees steers the organization by developing, reviewing and renewing the organization's Strategic Plan at regular intervals. The Trustees initiated the most recent strategic plan renewal process in June 2008. Since that time a new environmental scan was completed, and between October 2008 and January 2009 hundreds of stakeholders both inside and outside the organization provided their feedback about the organization's current performance in three main functional areas and about what CAMH's priorities should be for the next three years. Additionally, employees and medical associates provided their views about CAMH as a workplace.

This report summarizes feedback from the consultations. The consultation methods and process are described in Section 2. Feedback from all sources is organized by CAMH's three main functions - clinical services; research and knowledge exchange; and policy, education and health promotion - presented in Sections 3, 4 and 5 respectively. Feedback on issues associated with fine-tuning and targeting CAMH's "specialty role" is summarized in Section 6. Finally, employee feedback on workplace issues is presented in Section 7.

2. THE CONSULTATION PROCESS

Approximately 900 people participated in the consultation process. Their active participation and thoughtful responses provide powerful evidence of stakeholders' high levels of interest in the issues facing the organization, and their desire to help shape CAMH's future.

ON-LINE SURVEY

Approximately **550** internal and **250** external stakeholders from across the province responded to an on-line survey between October and December 2008. The survey consisted of both multiple choice and open-ended questions related to CAMH's key mandates and strategic directions. In addition, the employee version of the survey asked questions about CAMH as a workplace, and about the organization's fiscal stewardship. **A copy of the internal stakeholder survey provided as Appendix "A".**

CONSULTATION MEETINGS

More than 150 people participated in 16 consultation meetings held between mid-November 2008 and mid-January 2009.

The discussions were great. I felt you heard me.

Each meeting opened with a brief presentation summarizing CAMH's history, evolution and current services and functions. Following the presentation, participants discussed the organization's strategic directions and key challenges. Many participants who provided written feedback after a consultation meeting expressed appreciation for the opportunity to give their input and generally made positive comments about the meetings themselves.

CLIENT AND FAMILY PERSPECTIVES

Although some clients and family members may have responded to the on-line survey and/or attended consultation sessions, special efforts were made to ensure that client and family voices were well reflected in "what we heard". In December 2008, CAMH's Empowerment Council (EC) worked with CAMH staff to develop a questionnaire targeted specifically to clients, and in January the EC managed the process of recruiting clients to complete the questionnaires and summarized the results. **The Empowerment Council report is attached as Appendix "B"**. The EC also included some discussion of key questions in a few of their site meetings and at their Annual General Meeting. Feedback from these discussions is also included in their report.

In addition, during the same time period, two consumer-led organizations, the Ontario Council of Alternative Businesses (OCAB) and the Parkdale Activity Recreation Centre (PARC) gathered feedback from CAMH clients who are involved with their organizations. A trained interviewer with experience of the mental health and addictions "system" interviewed 30 former and/or current CAMH clients drawn from Voices from the Street, the Dream Team, Out of This World Café, and the Consumer/Survivor Information Network. All those interviewed had received services from CAMH during the past two years. OCAB summarized the feedback from these interviews in a written report which is also attached as **Appendix "C".**

CAMH's Family Council also supported the consultation process by organizing and hosting a consultation session targeted specifically to family members. **Their report attached in Appendix "D".**

Feedback from all sources paints a rich picture of how CAMH is currently seen by its stakeholders, their needs and expectations about CAMH's role(s) and relationships in the broader mental health and addictions system, and how CAMH's employees perceive CAMH as a workplace.

3. WHAT WE HEARD ABOUT CAMH'S CLINICAL SERVICES

Survey respondents were asked to rate and identify priorities amongst eleven aspects of CAMH's clinical services. A majority of those who had an opinion gave "good" or "excellent" ratings to 10 of them. Stakeholders clearly regard CAMH as a leader in Ontario's mental health and addictions sector and on average have positive opinions about CAMH's clinical services. Ratings by internal stakeholders were consistently somewhat higher than those given by external stakeholders.

OVERALL QUALITY OF CLINICAL SERVICES

"Quality of care" received the highest average ratings from both groups: 86% of internal and 76% of external stakeholders who expressed an opinion rated the quality of clinical services as either "good" or "excellent".

A majority of clients interviewed by OCAB/PARC (63%) also said that CAMH provided good quality care and an additional 30% said that the care was somewhat good. Continuing on a positive note, 70% of those interviewed said that treatment was tailored to their individual needs; 80% said that CAMH staff acted on what they said they needed and most impressively, 83% said that they were better equipped to live their lives since getting services from CAMH. Only one client interviewed said services from CAMH had not made a positive difference for him. Of those who gave mixed reviews, the main reasons cited were quality of care received, wait times, lack of follow-up in the community and issues with particular staff.

Feedback in 22 client questionnaires collected by the Empowerment Council was relatively positive however in the in-person sessions, clients noted concerns about access to services, attitudes of physicians and staff and the limited range of treatment options available to offer true client choice.

EMERGENCY DEPARTMENT SERVICES

Although specific questions about the services of CAMH's Emergency Department (ED – sometimes called 'ER') were not asked either in the survey or in consultation meetings, many family members and a few clients introduced the topic in consultation meetings, expressing dissatisfaction with their experiences.

There needs to be a compassionate person right on the spot at Emergency to make a connection and talk with the person who brought in their family member/friend.

Some said that the waiting area and interview rooms did not provide a supportive or healing environment for people in crisis. They reported on the long wait to be seen by a doctor or a nurse, without any information about how long their wait would be. One participant described the staff as "sequestered behind glass partitions and avoiding eye contact with people waiting to be seen". Some also commented on how distressing it was to see police and people in restraints in the waiting area. Finally, family members were critical of the fact that there were no supports provided for family members and other caregivers when they accompanied a family member or friend in crisis to the ED.

These misgivings notwithstanding, most clients and family members said they would still be most likely to go to the CAMH Emergency Department in a crisis, rather than go elsewhere. They said that CAMH has far more expertise and experience handling mental health and addiction problems than any general hospital and that until they believed that other facilities had the same level of specialized expertise to deal with their emergencies, they would continue to go to the CAMH Emergency Department for help in a crisis.

ACCESS TO CLINICAL SERVICES

Clinical services at CAMH are good if you can get them when you need them. That's a big if.

In the on-line survey, both staff and external stakeholders identified "access to clinical services" as a problem. Of those who expressed an opinion about access, 49% of external and 37% of internal respondents rated access as only "poor" or "fair", while a majority of respondents also indicated that access to services ***should*** be one of the top-three priorities for clinical care at CAMH. Many respondents also commented that quality of care and access are inextricably linked and that timely access is a key element of good quality care.

While many current and former CAMH clients said they had been able to get clinical services when they needed them, this may reflect the fact that once a person is engaged with CAMH, accessing additional services is easier than it is for the general public.

Discussions at the various consultation sessions yielded many comments about the particular barriers to access that people experience:

- **Lack of information about how best to connect** with CAMH services, other than through the Emergency Department
- **No clear understanding of what services CAMH** provides - Many people don't know what help is available; they are unaware of or misunderstand CAMH's services; they don't know the appropriate referral protocols, many of which are different for different services. These issues may be especially problematic for newcomers and members of other marginalized communities.
- **Difficulty accessing assessments** (e.g. forensic or psychological testing) leading to delays in treatment for other problems
- **Long waiting lists** - While this is not always the case, this is certainly the perception "on the street". One consultation participant said that people who are not "sick enough" have to wait until they get sicker before they can access service.

There's no point being the best, and offering client-centred, safe care if no one can access the services or access is extremely difficult with too many hoops to jump through.

- **Requirement for a referral from a family doctor** – While this is not a requirement for all services, many people don't have a family doctor who can provide a referral to those services that do.
- **Lack of identification papers or health cards** required to receive service
- **Inability of people needing services to make or keep appointments** on their own, coupled with lack of family support or other escorts to get to CAMH for services.

- **Difficulty getting to downtown Toronto** – This is a particular problem for people from outlying areas.
- **Stigma -** Negative attitudes about mental health or addictions problems in general, or towards CAMH in particular, prevent some people from accessing CAMH's services**.** Some won't approach CAMH because they are generally distrustful of large institutions or strangers; some have negative associations with the old Queen Street Mental Health Centre. Many people think asking for help is a sign of weakness. Stigma associated with mental health or addictions problems can be intense, especially in some immigrant groups. Some family physicians from immigrant communities are hesitant to make mental health referrals because of the stigma.
- **Perceptions about CAMH -** "CAMH is homophobic"; "CAMH runs a Cadillac program for people who have already committed to making a change – it's not for people like me", "Marginalized women, street involved youth and/or other people with complex needs don't fit into the CAMH model"
- **Some people's lives are too complicated and precarious** (e.g. unstable housing, poverty, abuse, physical health problems) to make dealing with mental health and/or addictions problems a possibility for them.
- **Linguistic and cultural barriers** - Last, but not least, linguistic differences create barriers. Most services at CAMH are available only in English, but many people who need help don't speak English well or at all. People from some backgrounds (e.g. refugees) won't talk to a stranger on the phone about anything, much less about a mental health or addiction concern.

Throughout these discussions there was recognition that the mental health and addiction system is not adequately resourced to address all the needs, but also a belief that people in need should be able to expect better.

"*Linkages between CAMH programs"* was another aspect of clinical care with relatively low survey ratings from both internal and external stakeholder groups. 61% of internal and 52% of external respondents who had an opinion on this topic rated "linkages between CAMH programs" as "poor" or "fair". Understandably, external stakeholders were twice as likely as internal stakeholders to say that they didn't know enough to rate this aspect of care. In consultation sessions with staff, these survey ratings were reinforced, with staff commenting on difficulties in accessing services from another CAMH program.

SUGGESTED STRATEGIES TO IMPROVE ACCESS TO CLINICAL SERVICES

- More outreach in the community where people with mental health and addiction problems already congregate (e.g.; Sherbourne Health Centre, AA).
- Make more connections in person, rather than relying on paper to provide information about CAMH.
- Provide services out in the community, co-locating with other services (e.g. at shelters for people who are homeless).
- Assign staff, even if only once a week, to work or volunteer in the community (e.g. one agency has staff from Sick Kids who volunteer for them regularly).
- Pilot test "treatment on demand" approach (follow the Baltimore model).
- Create and disseminate visual aide for people who need help, showing the path to take to access CAMH's services.
- Train other service providers to identify mental health and addiction problems and make more appropriate referrals (teachers, school/ community liaisons, immigrant settlement workers)

CULTURAL DIVERSITY AND CULTURAL COMPETENCE

More than two-thirds of all survey respondents who expressed an opinion on this matter rated "cultural competence" of CAMH's clinical services as "good" or "excellent. However, 17% of internal respondents and 40% of external respondents said they did not know enough to rate this aspect of CAMH services. Further, cultural competence was least likely to be chosen by internal or external stakeholders as one of three top priorities that ***should*** be a focus of clinical care at CAMH.

In contrast with survey respondents, clients in interviews and other stakeholders at consultation meetings often expressed concerns about the cultural competence of CAMH's services. One client suggested that more people of colour ought to be involved at CAMH because the "face of addiction and psychiatric problems is not all white". Another participant also pointed out that Canada is a bilingual country, yet most services at CAMH are offered only in English.

SERVING THE ABORIGINAL COMMUNITY

At consultation sessions targeted to members of Aboriginal communities, participants told us that CAMH's services are not always sensitive to the culture of Aboriginal clients or that of Aboriginal service providers. They noted that their communities have a history with mental health and addiction issues, and that traditional knowledge and approaches, as well as western medical knowledge should be incorporated into the services provided to their communities.

They recommended a stronger CAMH focus on issues of particular concern to Aboriginal communities, such as Fetal Alcohol Spectrum Disorder; inter-generational trauma and its effects on people, families and communities; specific needs and issues of Aboriginal people in urban centers and in remote communities with few services. They encouraged CAMH to strengthen its support to Aboriginal communities to build internal capacity to address mental health and addiction issues through training and certification of service workers.

Some people don't know us. There's a need for more internal work with CAMH's own staff - training in cultural sensitivity, understanding aboriginal people, historical information. All CAMH staff should be required to take this training; given staff turnover, this training needs to be delivered periodically.

Participants also strongly recommended regular training for CAMH staff regarding Aboriginal community issues and needs. They suggested this training should be mandatory for all CAMH staff and should include both historical information about Aboriginal people and ideas about how to work with Aboriginal people in ways that respect Aboriginal culture and traditions.

SERVING OTHER CULTURAL AND LINGUISTIC MINORITY GROUPS

People who are new to Canada also need CAMH's services to be more responsive to their cultural and linguistic differences. Representatives of a small community agency elaborated on the challenges faced by Korean immigrants in Toronto. Although they spoke only about immigrants from Korea, their comments would also apply to other newcomer groups.

When people immigrate to Canada they leave behind family, friends and all that is familiar. The stress of such dislocation is often exacerbated by war and other difficult circumstances in the country of origin. Sometimes extreme stress triggers mental illness or addictive behavior in a person who is vulnerable to these disorders. Stigma associated with mental health and addiction problems is very high amongst some groups and families are more likely to abandon a relative who is mentally ill or addicted than lose face by continuing to associate with him or her.

Community psychiatrists are in short supply in the GTA. This is especially the case for community psychiatrists who deliver services in languages other than English. Few culture-specific community agencies have sufficient resources to adequately respond to the mental health or addictions problems presented by people in their communities. Finally, few new immigrants know what mental health and addiction services are available in the GTA; many have never heard of CAMH.

Given the perception of CAMH as the leader in the field, many immigrant service providers look to CAMH to provide appropriate services for their clients, to give them advice about what else their organizations can do to support individuals in crisis, and to help them work with their communities to reduce stigma associated with mental health and addictions problems.

With immigrants now comprising more than half the population of the GTA, and many more expected to settle here within the next decade, demands on CAMH to provide culturally/linguistically appropriate clinical services are likely to grow.

FAMILY-CENTERED SERVICES

Thirty-seven per cent of external and 22% of internal survey respondents said they did not know enough to rate the family-centered aspect of clinical services. Those who did rate this aspect made nearly identical assessments of family-centered clinical care at CAMH. Roughly two out of three in both groups rated family-centered care at CAMH as "good" or "excellent"; roughly one in three rated it as "poor" or "fair". Only 10% of external stakeholders surveyed and 8% of internal stakeholders said that family-centered care should be a top area of focus for clinical services.

The last word is with the physicians. If the physician doesn't believe in family-centered care it doesn't happen.

People whose relatives or loved ones have mental health and/or addiction problems saw the situation very differently. They said that although CAMH has expressed a commitment to family-centered care, it is not yet happening in practice. Members of CAMH's Family Council noted that although a plan for family-centered care at CAMH has been in development for five years, real change in this area is not evident.

Family members at the consultations identified the complexities surrounding family involvement in matters of care, notably the requirement to protect the privacy of the clients, and the fact that some clients do not want their families involved. Nevertheless, family members said that their own lives are inevitably and profoundly affected by their responsibility and concern for loved ones who have major psychiatric disorders or addictions, and that they also need support.

"Family members suffer collateral damage when a relative's illness takes hold".

SUGGESTIONS FOR WAYS TO BETTER SUPPORT FAMILIES

- Research family-related issues to inform changes in practice, including:
  - Looking at collateral damage to caregivers.
  - Examining patient outcomes related to family involvement and support.

- Develop more informal support groups for family members.

- Help family members access individual and family therapy for themselves more quickly. One person said, "***Waiting for two or three years for help doesn't help".***

- Ensure that CAMH staff gives family members information about all available family supports as soon as possible.

- Have someone at Emergency whose job is to help family members feel better and welcome when they bring someone into emergency. One person said, ***"Many countries have certain people on the health care team whose role is specifically to support families".***

4. WHAT WE HEARD ABOUT CAMH'S RESEARCH AND KNOWLEDGE EXCHANGE

CAMH's research is better known in national and international research communities than it is at home.

CAMH's researchers and research projects are well known and highly regarded in the national and international academic / research community. CAMH's research grants and contracts have tripled from $13 million to $39 million in the past 10 years; annual citations of CAMH research in the Science Citation Index have increased from 2500 to 5500; and 22 CAMH scientists are among the top 1% most frequently cited researchers in the world. However, closer to home, while CAMH's external and internal stakeholders are generally aware that research is an important function at CAMH, many say they know little or nothing about specific research projects or findings.

Broadly speaking, CAMH undertakes four types of research: fundamental neuroscience; brain imaging; clinical research; and social / prevention / health policy research. Roughly 70% of external and 50% of internal stakeholders who responded to the on-line survey said they didn't know enough about CAMH's research in fundamental neuroscience or brain imaging research to rate it. On average approximately 33% of external stakeholders and 25% of internal stakeholders also didn't know enough about CAMH's clinical research or social / prevention / health policy research to rate it.

Among external stakeholders who did express opinions, clinical research was the most highly rated area, with close to 90% of those who answered rating it as "good" or "excellent". Other areas of research were also mostly viewed as "good" or "excellent". Internal stakeholders gave brain imaging research the highest rating, with 86% saying that

it was “good” or “excellent”, with the ratings for other areas not too far behind.

Responses to a number of survey questions give the impression that CAMH’s local stakeholders are most interested in directly apply findings from CAMH’s research to their own practice, and possibly less interested in the contribution CAMH’s research makes to the broader knowledge base. Both internal and external stakeholders gave the lowest ratings to: “integration of research findings into clinical practice”; development and dissemination of best advice/best practices”; and “collaboration with internal stakeholders and community partners”.

When asked to identify the top priorities for research and knowledge exchange, both internal and external respondents most frequently selected “clinical research”; “integration of research findings into clinical practice”; and “education and training of health professionals”.

SETTING AND IMPLEMENTING CAMH’S RESEARCH AGENDA

What’s the point of doing great research at CAMH if we don’t know about it, or can’t use the findings to improve our clinical services?

CAMH’s local stakeholders would like to have input into its research agenda, but don’t know if this is possible or how the agenda is set. In consultation meetings with staff some said that CAMH follows a university-style selection process when hiring senior scientists. Individuals with exceptional credentials, reputations and a good track record in securing external funding are hired. Their research interests (and resources) then drive CAMH’s research agenda. Research associates and assistants are hired on limited term contracts, in conjunction with specific research grants.

As a consequence, some suggested that the current staffing model for research does not promote the establishment of a research agenda based on the issues of highest priority to CAMH’s stakeholders and does not foster opportunities to integrate research into practice. An alternative approach was suggested, whereby CAMH stakeholders would identify research needs and interests first, and then highly qualified scientists working in those areas would be recruited and hired. Some also suggested that increasing the number of research associates employed as permanent staff could help improve knowledge transfer and the integration of research findings into practice at CAMH.

Although far from the majority opinion, a number of those consulted said that research at CAMH is being supported at the expense of clinical services. They suggested that there is little point to doing research if there are not enough people around who can interpret and apply the findings to practice, and recommended that research dollars should be used to put more workers in the field.

SUGGESTED WAYS TO EXTEND THE REACH OF CAMH RESEARCH

- Use the internet to enhance communication:
  - Develop a subscription service that uses email to announce new research
  - Ensure that information about CAMH research is included in existing “list serves”
  - Use CAMH’s website to announce and link users to research

  - Develop and use a comprehensive and up-to-date e-mail list of stakeholders (including clients and family members) to notify them about research and reduce reliance on expensive printed reports
  - Provide periodic information sessions delivered in person or via web-cast

- Streamline dissemination by providing research information to a larger agency / organization which will disseminate the information further
- Put out 'bite-size' pieces of information
- Hold research information sessions on a regular basis
- Hold "Lunch and Learn" sessions about research

PROFESSIONAL EDUCATION

CAMH is recognized for the training it provides to people planning to work or working in the mental health and/or addiction fields. The training is valued, with approximately 75% of internal and external stakeholders rating it as "good" or "excellent". Some stakeholders, however, said that CAMH training can be very difficult to access, and it is not always delivered at a level appropriate for the people being trained. For example, front-line staff in some mental health and/or addictions organizations lack formal credentials or previous job-related training. One stakeholder said that when CAMH provided training for their front-line workers the level of training was too high for the target audience.

CAMH seems top heavy in terms of research while out here in the community we need way more front line addictions workers dealing with real every day issues.

In the consultation sessions, another idea emerged – the notion that classroom or on-line training is ***necessary***, but not ***sufficient*** to support front line workers to address the challenges they face in day-to-day practice. Collaborative care models, providing primary care providers with regular access to psychiatrists and other clinical experts, were described as promising approaches for building mental health and addictions capacity across the health and social services system. Some CAMH staff and community partners with experience working in this way reported on the effectiveness of building relationships and shared approaches to treatment as the way to "bring it all together".

5. WHAT WE HEARD ABOUT CAMH'S WORK IN HEALTH PROMOTION, EDUCATION AND POLICY

On average both internal and external stakeholder groups believe that CAMH is doing a good job meeting its health promotion, education and policy mandates, with internal stakeholders slightly but consistently more likely to rate these activities higher than external stakeholders.

PRINTED MATERIALS FROM CAMH

CAMH is generally seen as a trusted, unbiased source of information on mental health and addiction problems and consultation participants and survey respondents were generally aware of and familiar with CAMH's print materials. Opinion among them was divided as to how useful some types of printed materials were for certain audiences and specific purposes.

Pamphlets were seen as most suitable for the general public and for clients looking for very basic information about a particular topic. Pamphlets were also seen as useful for entry-level and front-line staff when they provide very specific information on how to address specific problems at work.

Pamphlets were seen as less suitable or unsuitable for: experienced practitioners, people with low literacy skills, and/or newcomers to Canada who have English as a second language. If they are to be useful to many immigrants in the Toronto area, CAMH's print materials need to be translated into many different languages – more than is currently the case.

Young people were seen as more likely to trust information from their peers than they are to trust information from other sources, and more likely to access information through their computers than they are to read pamphlets.

Many stakeholders said that providing information on paper alone is never as effective as providing "paper" as well as person-to-person contact to explain what's on the paper and how it can be applied. Several stakeholders suggested that CAMH should use its resources to increase opportunities for person-to-person contacts instead of producing more information pamphlets.

CAMH'S WEBSITE – WWW.CAMH.NET

A majority of stakeholders agreed that the CAMH website should be an important source of information on CAMH and on mental health and addictions. Some said a subscription-based CAMH website would be less expensive to develop and maintain than printing and distributing more pamphlets.

Most stakeholders who have seen the CAMH website said it needs to be significantly improved to make it more useful and accessible. They say it is difficult to find information they are looking for. For example, something as basic as information on how to make a referral to CAMH is hard to find. Too much information on too many topics is presented at once. It's too easy to get lost on the site.

Some stakeholders suggested that the CAMH website should provide distinct sections for different user groups: e.g. general public, clients, family members, practitioners, researchers, etc.

RECOMMENDATIONS FOR NEW CONTENT

Some consultation participants identified specific needs for new "content" from CAMH, to be made available via outreach to communities across the province, resource materials and/or training. These included:

- resources designed and delivered from a multicultural and health equity perspective;
- resources designed specifically for primary care physicians working with new immigrant communities;
- information on how to persuade addicted individuals to deal with their addictions
- information on how to calculate the number of mental health and addiction professionals needed in a specific community;
- information on handling mental health / justice issues; and
- information to increase public awareness about the links between addictions and mental health problems.

6. WHAT WE HEARD ABOUT CAMH'S SPECIALITY CLINICAL ROLE AND ITS RELATIONSHIPS WITH OTHER SERVICE PROVIDERS

DEFINE SPECIALIZED CLINICAL SERVICES

There's broad agreement among stakeholders that CAMH can't do everything, and needs to specialize. However, the reality of insufficient resources for mental health and addictions services in the community, coupled with perceptions of unparalleled expertise at CAMH, leave many still expecting CAMH to be all things to all people.

Specialty hospitals like CAMH can't fulfill their specialty role – there aren't enough services in place in other settings.

Stakeholders were unable to agree on what CAMH should specialization in, and which services CAMH should stop providing. When asked which aspects of clinical service CAMH should provide, over 90% of all survey respondents said CAMH should either directly provide services in certain areas, AND/OR provide support along with consultation in these areas. They included: assessment, emergency services, crisis support, acute care inpatient services, specialty inpatient services, post discharge follow-up, outpatient services, medication management, primary care and continuing / chronic care. Respondents were slightly less likely to want CAMH to directly provide or support laboratory services (roughly one in four say CAMH should have no role in this) or employment, housing and income supports (one in five say CAMH should have no role in providing these services).

Some consultation and survey participants said CAMH should specialize in clinical services for clients with complex needs (e.g. psychiatric disorder plus homelessness plus mobility issues plus other medical conditions), concurrent disorders, and/or conditions that have not been satisfactorily treated through previous treatments.

Some spoke of specialization in terms of diagnostic categories, and said CAMH should provide services for clients with schizophrenia, depression, bipolar disorder, personality disorders, alcohol addiction, drug addiction, gambling addiction, internet addiction.

Still others said CAMH should specialize in providing services to people in demographic groups that are currently underserved: for example, seniors, veterans returning from

Afghanistan, relatives of veterans, LGBT people, youth with addictions, street involved youth.

Stakeholders at one acute care hospital emphasized the need for CAMH to specialize in providing beds and services for the very small number of people who are much too ill and/or too aggressive to benefit from the type of care that can be provided in acute care or community settings. They said that when patients with extreme problems are in general hospital psychiatric beds it becomes much more difficult for them to meet the needs of the patients they are equipped to serve. In their view psychiatric units in community hospitals must have dependable tertiary care back-up, and CAMH is the organization to provide it. Furthermore, they emphasized that some people are just too severely ill to be able to safely live in the community without intensive support and supervision. The level of resources in the community available to provide support and oversight for these individuals is seriously inadequate.

One consultation participant said that CAMH should take advantage of economies of scale when making decisions about what to specialize in, continuing to deliver the large programs that CAMH currently delivers, and supporting community organizations to take on and provide some of the smaller programs.

Another consultation participant suggested CAMH take an aggressive approach to rationalizing what it provides. He said CAMH should decide what it will and won't do, and who it will serve, and then refuse to provide any additional services or serve any other clients. He thought that taking a hard-line approach to boundaries would force the rest of the system to deal with the issue of gaps in service and finally ensure that a continuum of care exists in the larger system.

THE ROLE OF LHINS

Several consultation participants said that CAMH has neither the mandate nor the resources to develop and maintain a broad continuum of care for clients of mental health and addiction services on its own. Local Health Integration Networks (LHINs) are expected to play this central coordination role, but to date they have not actively embraced it. In addition, as a provincial resource, CAMH's services and clients are not contained within the boundaries of a single LHIN. This complicates the challenges associated with enabling and supporting CAMH to be part of a continuum of care.

One consultation participant suggested that the Child Health Network model currently in place in Ontario could provide a useful model for mental health and addiction service coordination. Another noted that Quebec assigns responsibility for providing mental health and addictions services strictly based on geography. Each general hospital in a region is mandated to provide psychiatric services to anyone in the region who needs them. The Douglas Institute is mandated to provide back-up to the general hospitals.

The bottom line seems to be that an adequately resourced and centrally coordinated continuum of care is a prerequisite to finer specialization by CAMH. Furthermore, more effective and structured cooperative relationships between service providers, including CAMH, are necessary. One participant who said that better and more structured relationships are required to improve coordination of services saw a need for regular meetings between service providers that systematically provide opportunities for "check ins" as well as strategic conversations.

WORKING WITH CAMH

Consultation participants said that community agencies and CAMH both benefit from working together. External stakeholders said that CAMH has valuable expertise and provides training that increases the capacity of local services. Some noted successful collaborations with CAMH on specific projects. Some said that working with CAMH enhances their agencies' ability to link their clients with services they can't provide on their own. Finally, some said that being associated with CAMH helps boost their own agencies' credibility in their communities because CAMH is a "brand" that is recognized and credible.

Many external stakeholders also pointed to benefits that CAMH could realize, but often doesn't, as the result of working cooperatively with community-based service providers. Some said that CAMH staff members don't always understand or value the role played by local service providers or value the different approaches to healing mental illness and addictions problems that other groups employ (eg. women's groups, Aboriginal and other cultural groups). Some said that they'd like to get a little more respect and a little less ego from CAMH.

7. WHAT WE HEARD FROM EMPLOYEES ABOUT CAMH AS A WORKPLACE

Employees responding to the survey rated 15 aspects of CAMH's efforts to support a healthy workplace. "Library services and supports across the organization" received the highest ratings with 74% rating them as "good" or "excellent". At least 60% of respondents also gave mostly "good" or "excellent" ratings to CAMH's efforts to: recruit staff from diverse / marginalized communities (61%); provide them with information needed to feel connected to the organization (62%), accommodate employees' special needs (62%) and provide competitive employee benefits (60%).

However, 60% of employee respondents gave only "poor" or "fair" ratings to each of the following aspects: "providing timely feedback on performance", "rewarding and recognizing those who exceed expectations", and "encouraging / supporting the development of healthy teams". A smaller majority of respondents also gave ratings of "poor" or "fair" to "respecting the need for work / life balance (57%)", and "managing workplace conflict, harassment and violence (51%)". 43% said that CAMH was doing only a "poor" or "fair" job protecting staff safety.

Employees were also asked to rate the importance of each of these 15 aspects of CAMH's efforts to support a healthy workplace. In general, employees felt that all the areas listed are important. The two areas most frequently rated as "important" or "very important" were "training to enable staff to carry out their responsibilities (96%)", and "access to information and tools needed to carry out responsibilities (95%)".

The issue raised most often in survey comments was the perception of CAMH as unnecessarily top-heavy - with too many managers and executives. The second most frequent comment described the climate at CAMH as "distrustful", "disrespectful" and "unsupportive".

Additional comments and concerns focused on employees' workloads (too heavy); a desire for greater respect for work/life balance; the need to improve teamwork; safety; and lack of recognition for exceeding expectations.

FINANCIAL STEWARDSHIP AT CAMH

Approximately 347 employees of CAMH responded to questions about CAMH's fiscal management and opportunities. Roughly two in five employees said that CAMH is managing its financial resources appropriately, while slightly more than that said they have no opinion on this topic, or don't know. The remaining respondents said that they don't believe finances are being managed appropriately at CAMH. Only one in eight employees agreed that "The allocation of resources within the organization is well understood". More than half disagreed with this statement, and the remainder had no opinion or said they don't know.

A range of recommendations were provided to "save money and make CAMH more fiscally responsible" and include:

- Review and evaluate services and cut back on those that are not needed, ineffective, or delivered better or more cheaply by other organizations.
- Streamline/reduce salaries of management
- End contracting out
- Revise administrative procedures to effect savings
- Go greener
- Purchase existing information technologies instead of developing them from scratch
- Revise some benefits and perks for employees
- Generate new revenues
- Shift priorities and defer new development

8. CONCLUSION

In summary, our various stakeholders were largely complimentary about the work of our organization and about the role that CAMH plays in the mental health and addiction system. But they also raised issues and provided suggestions for improving performance in some key areas by:

- expanding our reach to better include diverse communities;
- improving access to the programs and services we provide;
- providing more treatment options for clients and supports for families;
- communicating our research findings and their potential impacts more broadly;
- providing more support to service partners "in the moment", and not only through publications and training programs; and
- improving some of our work place practices.

Many expressed an interest in hearing more about CAMH's plans and future directions in an on-going way, as well as a willingness to work with CAMH to coordinate efforts and achieve a better mental health and addiction system.