EMPOWERMENT REPORT

(The Newsletter of the Empowerment Council)

Life on a CAMH Unit

By Jennifer Chambers, EC Executive Director

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What is life like on a psychiatric unit from the client point of view? Are people getting their needs met? Clients are rarely asked for their opinion in a forum that is not controlled by a questionnaire or inhibited by the presence of staff. I talked to clients on some CAMH units with high security levels: 3-1, 3-3, 3-5 at Queen St and GPU/ACU at College St.

Staff are talking amongst themselves about how they want the units to be and the Empowerment Council (EC) suggested that clients should also be able to talk about this with other clients. The EC has been assisting with this until peers are hired by CAMH to carry it forward. There is a potential conflict of interest in speaking for clients while working directly for CAMH (which is why the EC is a separate organization), and we will need to be alert to this and supportive of the client voice. As part of a pilot project at CAMH called **Safewards**, the needs clients raise should be getting addressed. (GPU will be dropping out of the pilot because of high staff turnover so the EC will be taking up those issues.)

Clients had many thoughts on what would make life on the unit a better experience for more people. To protect people's anonymity, this first report is a summary of the points that were made again and again by clients on every unit visited (unless a unit is specifically mentioned).

This is what people had to say:

Every unit had staff that clients described as good, bad, and in between. Most appreciated were staff members who talked to people like human beings, who were supportive and kind, who helped people get their needs met, and who initiated real conversations. Assistance in getting out of doors was also valued. Staff who only spoke to people to get their answers to questions to put on the chart, and who generally seemed unhappy to be there at all, were not so good to be around. The worst were staff who acted as if everything they did was a favour (as people pointed out, they're paid to be there, right?) those who belittled, constantly criticized, and did not seem to believe anything a client said. For example, a staff person said to a client "If you're so smart, why are you here?" Some staff treated clients quite differently from one another. People do want to be treated as individuals, but at times there was clearly favouritism, with others not treated as well.

Clients were often compassionate toward staff and the pressures they were under, such as the paperwork they had to complete. At the same time they felt they had the right to expect fairness, respect and empathy and to not be treated as a burden.

A common source of frustration for clients was asking and waiting for so many things, never knowing if staff would get back to them about their request at all, because responses varied. Many people expressed sympathy for all the work staff had to do, and felt some staff really tried but did not often feel that staff understood what it was like to feel so powerless about every little thing in your daily life.

People frequently said that the answer that's offered to all their problems is that it's an illness, it requires medication. Some people agreed with this, others identified sources of hurt and pain in their early and current lives. For example, someone who raised an abusive parent as the source of his distress was told this was not their real problem. Some found medication beneficial and some did not. Those who didn't did not feel heard or believed. Only one client thought medication alone was enough. Most people wanted access to supports, especially therapy, which they often had little of while in the hospital, and typically knew there would be even less outside (though a few had good therapists in the community). Some said they'd been there a long time with no real help.

Lack of privacy was stressful. It felt invasive if staff entered a bedroom without knocking, or pulled back a curtain while they were showering. Being on camera all the time, if in a seclusion room, was also a source of stress.

Food was appreciated for its presence, but clients wanted more variety, and just more. Fresh fruit and vegetables were craved.

It is not easy for clients to be heard in the life of a psychiatric unit, individually or collectively. People tend to fear repercussions, which is not an unrealistic fear, especially on forensic units where a negative comment about somebody in their record can affect their liberty at their next ORB hearing. (We informed people that they do have the legal right to see and add their own comments to their record.) We believe that by meeting clients' needs, to the greatest extent possible, life can be better and safer for everyone on the unit. We can all reach for the greater good together.

Clients Suggest What Could Make Life On The Unit Better:

- Staff who start friendly conversations and listen with caring would make relationships better. Good listening would be hearing what people say about themselves, their lives and their needs, not imposing ideas about what's wrong and what's needed.
- Write positive things about clients in their record – notice the positive things.
- Be responsive to requests by clients – this could reduce a lot of stress. If a person cannot have what they requested, explain why not and if possible how and when they might get it. Keep commitments. If what was committed to is not going to happen, acknowledge that this is the case and try to work something out. It would be less stressful for everyone if there were fewer restrictions about what a person can have and do while on the unit.
- Respect Privacy - Knock before entering a bedroom; do not enter shower area without consent. Do not post clients' first and last names where everyone can see them.
- Don't have a camera trained on a person using the toilet or doing other private things.
- Have opportunities on the unit to learn, to do art and to access computers.
- Get exercise equipment on the unit if there isn't any (GPU).
- Allow people outside more than once a day, never less than that.
- Post rules and reasons for them so everyone can know what to expect.
- Recognise people simply have different sleep cycles, it's not a fault.

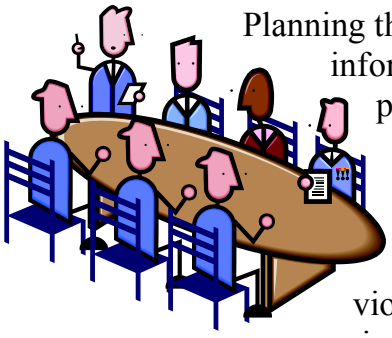
Developing an Anti-Violence Analysis with Mental Health and Addiction Service Users and Peer Leaders/Workers

By Stef Mendolia, EC Volunteer

The Empowerment Council organized a session on developing an anti-violence analysis with the service-user and peer support worker population. In order for peer workers to come prepared for an interactive session to engage in critical thinking and reflection, it was important to clarify that the session was not just a presentation on the contents of the previously published Psychiatric Disabilities Anti-Violence (PDAC) report but an opportunity to share and discuss overall issues related to violence that emerge personally or in the workplace. The event took place in August 2016 and was described as, "a reflective follow-up session to foster dialogue on the ways structural violence and systemic oppression affect consumer/survivor communities. The goal is to engage with a series of questions that will encourage us to think critically on what our place is in finding appropriate ways to respond to conflict arising from violence in our communities of practice".

Some questions included:

- How can peers utilise their positions to advocate in the best interest of service-users inside and outside the mental health system and as fellow peer-workers?
- What are some strategies that can be developed to address tension in the workplace?
- How do we make the most out of the amount of power we have as peers or allies working for change?



Planning the session focused on how the objectives were woven into the information presented, including prompting questions that allowed participants to consider their place in the conversation on violence as consumer/survivors and peer leaders, as well as individuals positioned across intersections of oppression working within activist settings and community organizations. Much like the PDAC report, the EC entered the conversation on anti-violence with 'what we already know' about violence, integrating the information contained in the report with the experience of the facilitators as advocates working in field.

We wanted to ensure it was clear that while the issue of police violence is serious and relevant to our discussion, it was not the sole issue of focus. Police violence is part of the big picture of how certain lives are valued over others. The death of Andrew Loku, a 45 year-old Black man who was shot to death in his Canadian Mental Health Association-run housing unit in July 2015, prompted a great deal of public interest on police violence towards people of colour with a psychiatric disability. At various points since Mr. Loku's death, Black Lives Matter Toronto has organized demonstrations to demand transparency and accountability measures from the Toronto police. Dr. Jim Edwards, Loku inquest coroner, stated that, "there was 'nothing specific' about the shooting incident that compelled the call for an inquest. Rather, it was pressure from Black Lives Matter and others" (Alex Barringal, April 2016). The subject of violent policing evokes a high intensity of emotional response, given that the purpose of police is to protect the public from harm and wrongdoing; however our session was aimed at highlighting the more nuanced, and less publicly visible ways violence towards people with psychiatric disability happens across the experiences of various marginalized groups.

The participants were provided with a handout that included the session's learning objectives, a list of reflection questions to stimulate discussion and an evaluation form. We found that when talking to peers working with mental health and addictions organizations and community efforts, the act of encouraging individuals to get out of the "representation" mode and into the critical thinking and personal reflection mode proved to challenge the way social responsibility occurs as a result of how personal privilege and power can be downplayed in the role of "worker". Peers discussed how it is difficult to do their work the way they would ideally like to because they are limited by the flaws within the current system that stem from the lack of priority placed on the voice of the service-user. For this reason we find that conversation on violence is hindered by peers juggling the positions they hold that may conflict on individual and structural levels.

A member of a peer-led addictions and harm reduction organization for LGBTQ youth spoke out on how violence should be taken up as a community issue, and that while it may be difficult to formalize, there are ways that organizations can have a practical approach to grapple with violence in the community and the workplace. We felt that mental health organizations would benefit from collaborating more with addictions and harm reduction community activists as a place to further develop an anti-violence analysis for the broader mental health and addictions peer movement. There was dialogue on how the professionalization of peer support work, via the creation of accreditation standards and governing bodies, have pros and cons for workers but necessitate the importance of putting violence as it exists in its many forms on the agenda.

Ultimately, the lesson learned from the work done to organize this reflective session was a further understanding of how violence enacted towards people with psychiatric disability is a complex issue around which to mobilize.

EMPOWERMENT COUNCIL GENERAL MEMBERSHIP FORM

EC Statement of Purpose: *To conduct system wide advocacy on behalf of clients*.

Contact Information: ***(****Please Print Clearly****)***

Name _____ Address _____

City _____ Postal code _____

Telephone _____ Email address _____

I have used mental health and/or addiction services (*check those that apply*):

College Street site ____ ***Queen Street*** ____ ***Other: Mental Health*** ____

Russell Street site ____ ***White Squirrel Way*** ____ ***Other Addiction*** ____

I support the purpose of the Empowerment Council:

Signature _____

Send to: **Empowerment Council, 33 Russell Street, Room 2008, Toronto, ON M5S 2S1**