
ON OUR WAY
Mental Health Commission of Canada
Annual Report 2009-2010
MENTAL HEALTH COMMISSION OF CANADA
COMMISSION DE LA SANTÉ MENTALE DU CANADA

"Not one person has asked to suffer from mental illness ... the point I want to get across is that people with mental illness should be helped a lot more, and should not be judged and discriminated against. I have [shared] this story for my son because I want people to show compassion and understand he didn't ask to be born this way and that he deserves a fair chance at life itself."

Public online participant

FACT

Utilization of all health care services is highest for the diagnosed mentally ill, lowest for the non-mentally ill, with those in the undiagnosed category in the middle.

K-L Lim; P Jacobs, A Ohinmaa, D Schopflocher, CS Dewa. A new population-based measure of the economic burden of mental illness in Canada. Chronic Diseases in Canada. Vol 28, No 3, 2008.


Our Journey
In 2007, the Mental Health Commission of Canada began an ambitious journey. Part exploration, part marathon, this expedition has a very clear goal: We're driven to focus national attention on mental health issues, and to improve the health and social outcomes of people living with mental health problems and mental illness.

STARTING POINT

In 2006, the Senate Committee on Social Affairs, Science and Technology released *Out of the Shadows at Last*, the first ever national report on mental health. A key recommendation of this report was that Canada needed a vehicle for focusing national attention on mental health and for undertaking related tasks at a national level. As a result, the Mental Health Commission of Canada (MHCC) was created in 2007.

SETTING OUR GPS

Our Vision
To create a society that values and promotes mental health and helps people living with mental health problems and mental illness lead meaningful and productive lives.

Our Mission
To promote mental health in Canada, to change the attitudes of Canadians toward mental health problems and mental illness, and to work with stakeholders to improve mental health services and supports.

ALONG THE WAY

- We are developing the first ever *mental health strategy* for Canada
- We are changing stigmatizing attitudes and behaviours
- We are addressing homelessness and mental illness
- We are facilitating knowledge exchange
- We are engaging Canadians in a social movement

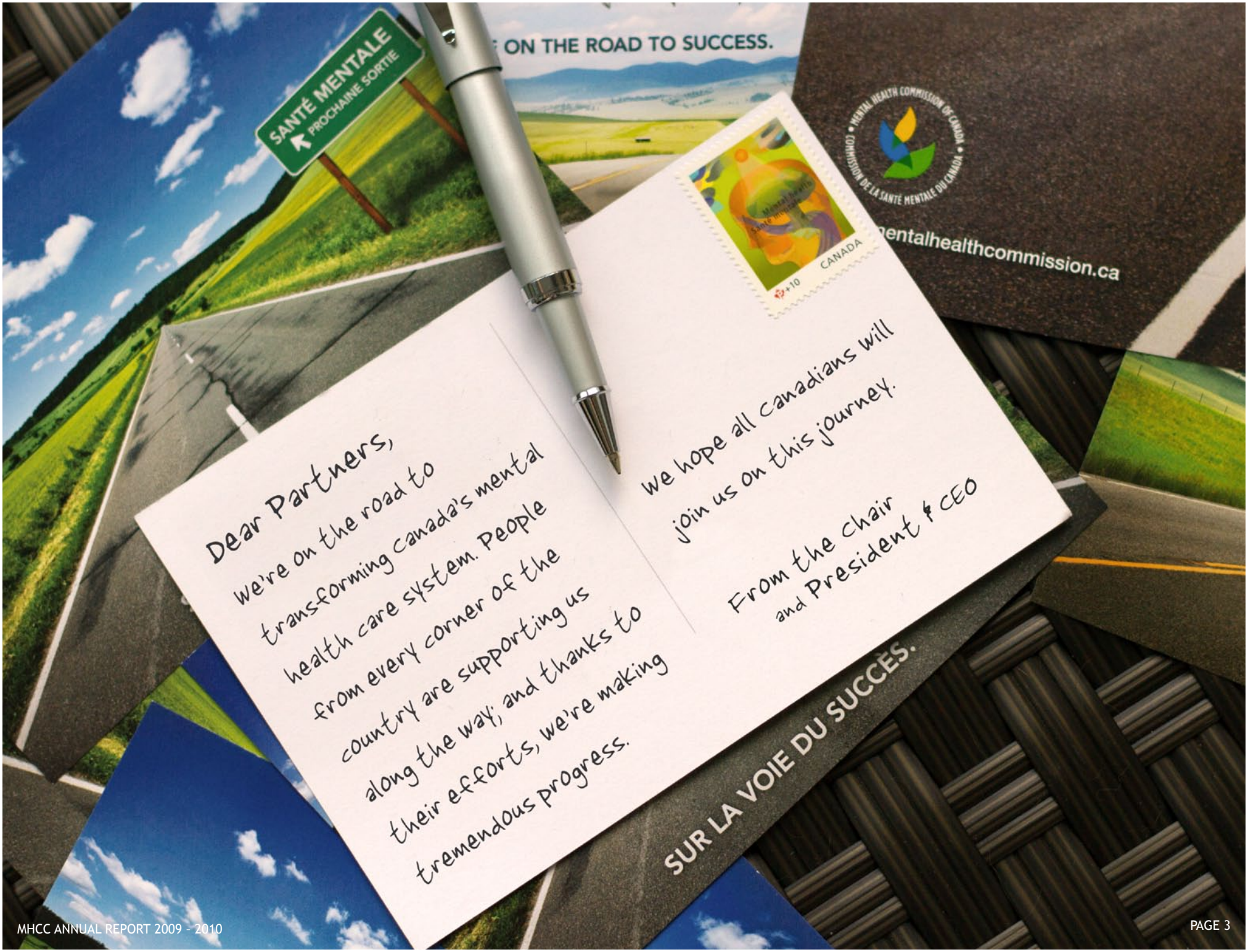
"We inhabit our bodies; we live in our minds. The great paradox is that the very space within which we experience our lives, hold our memories, make our decisions and share the joys of being alive is at the same time the space that we most stigmatize and neglect in health care. Our health care could more easily move ahead by setting mental health on top."

Stakeholder submission

FACT

Only about one-third of those who need mental health services in Canada actually receive them.

Statistics Canada: Canadian Community Health Survey: Mental Health and Well-Being, 2003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PROCHAINE SORTIE
ON THE ROAD TO SUCCESS.
CANADA
+10
mentalhealthcommission.ca
SUR LA VOIE DU SUCCÈS.
Dear Partners,
We're on the road to transforming Canada's mental health care system. People from every corner of the country are supporting us along the way; and thanks to their efforts, we're making tremendous progress.
We hope all Canadians will join us on this journey.
From the Chair and President & CEO

Our ultimate destination is an integrated mental health system that places people living with mental illness at its centre. In 2009, the Mental Health Commission of Canada passed several key milestones that brought us closer to that goal.

We released *Toward Recovery & Well-Being,* the framework for Canada's first ever mental health strategy. The framework envisions a country in which all Canadians have the opportunity to achieve and maintain the best possible mental health and well-being, and it outlines the actions needed to address the mental health needs of Canadians.

In developing the framework, the Commission worked with a broad cross-section of stakeholders from across the country, including provincial and territorial representatives as well as other levels of government. With the framework in hand, we are now formulating the actual changes required to transform the system.

Also this year, we launched *Opening Minds,* the Commission's 10-year anti-stigma / anti-discrimination initiative aimed at changing the attitudes and behaviours of Canadians toward people living with a mental illness.

This is the largest systematic effort in Canadian history to reduce stigma. We are partnering with organizations and communities that are already working on projects to reduce stigma. We are evaluating their projects for their effectiveness and potential to be expanded nationally.

A third major milestone for the Commission in 2009 was the launch of *At Home / Chez Soi,* our ground-breaking national research initiative. Located in five Canadian cities, *At Home / Chez Soi* is aimed at finding the best way to provide housing and services to people who are homeless and living with a mental illness.

Working closely with exceptional partners across all sites, we were all very happy to witness the first participants entering the research project and being given a place to live and the services and support they require. Soon, through the *At Home / Chez Soi* initiative, a total of 1,325 homeless Canadians with a mental illness will have a home and Canada will be on its way to identifying the best course of action to address the issues of mental illness and homelessness.

During the past year, the Commission also moved forward with its Knowledge Exchange Centre. Having access to multiple sources of knowledge and having the ability to share it is fundamental to transforming the system of care. This year, we engaged with various organizations across the country that are involved in knowledge exchange and identified how the Commission can add value in this area.

In addition, the Commission's eight advisory committees are going full steam ahead on 24 projects that are contributing to the work of the Commission. For instance, in 2009, we witnessed the publication of the first report by the Service Systems Advisory Committee on improving mental health services for immigrant, refugee, ethno-cultural and racialized groups. We encourage you to read about the exceptional work of each of the advisory committees in this report.

We are also moving forward with our *Partners for Mental Health* program to create a grassroots social movement committed to increasing public awareness about mental health issues through action. Creating a lasting social movement is a major undertaking, so we are taking a very deliberate approach and we are now doing the work required in order to launch Partners early next year.

Through the combined efforts of the Commission and many other mental health organizations across Canada, there is today an unprecedented level of interest in mental health issues in our country. Throughout 2010 and beyond, we plan to build on this increased awareness and get our message out to an even wider audience.

We want to thank the hundreds of people across Canada who work directly with the Commission — as full-time staff, as members of our eight Advisory Committees, and as Board members — for their hard work and dedication. The Commission is also honoured to be working closely with many great partners, including provincial and municipal governments, researchers, local service providers, as well as individuals who have experienced mental illness. We are very grateful for their commitment and support.

Working together with colleagues and supporters across Canada, the Commission is making progress, but we still have a long way to go. We are driven by the knowledge that our work will have a truly positive impact on the lives of people living with a mental illness and their families. By continuing to pull together, we will help make mental health a priority for all Canadians and bring mental illness out of the shadows forever.

Michael Kirby
Chair

Louise Bradley
President &
Chief Executive Officer


MHCC
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MENTAL HEALTH COMMISSION OF CANADA
COMMISSION DE LA SANTÉ MENTALE DU CANADA
Mapping The Way
In 2009, the Commission released the document *Toward Recovery and Well-Being*. This framework sets out seven goals for a comprehensive and person-centred mental health system that fosters the best possible mental health and well-being for everyone living in Canada. It will guide development of Canada's first ever mental health strategy.
M H C C

WHY A MENTAL HEALTH STRATEGY FOR CANADA?

While there has been tremendous progress in understanding how to enable people to recover from mental health problems and illnesses, nowhere in the country do people have access to a truly comprehensive and integrated system of programs, treatments, services and supports to meet their mental health needs.

Even though most jurisdictions have worked at improving the quality and availability of mental health services and supports, all too often the pressing needs of people confronting mental health problems and illnesses are not being met. Nor is enough being done to keep people from experiencing mental health problems and illnesses in the first place, or to improve the mental health status of the population as a whole.

A mental health strategy for Canada will help ensure that everyone in Canada — whether or not they are living with mental health problems — has the opportunity to achieve the best possible mental health. It will:

- Focus national attention on mental health issues
- Set clear targets for transforming the mental health system
- Promote recovery and well-being

DESTINATION

Toward Recovery and Well-Being outlines seven goals for the mental health strategy:

1. People of all ages living with mental health problems and illnesses are actively engaged and supported in their journey of recovery and well-being.
2. Mental health is promoted, and mental health problems and illnesses are prevented wherever possible.
3. The mental health system responds to the diverse needs of all people in Canada.
4. The role of families in promoting well-being and providing care is recognized, and their needs are supported.
5. People have equitable and timely access to appropriate and effective programs, treatments, services and supports that are seamlessly integrated around their needs.
6. Actions are informed by the best evidence based on multiple sources of knowledge, outcomes are measured, and research is advanced.
7. People living with mental health problems and illnesses are fully included as valued members of society.

Our next step is to define how these goals will be carried out.

GETTING THERE

The development of the framework document involved extensive consultation with the Commission's eight Advisory Committees and:

- A general online public consultation in both languages
- A series of twelve by-invitation regional dialogues (held in St. John's, Halifax, Montréal, Toronto, Thunder Bay, Winnipeg, Regina, Edmonton, Vancouver, Whitehorse, Yellowknife and Iqaluit)
- Three focused consultations in Ottawa with representatives of First Nations, Inuit and Métis organizations, federal departments responsible for policies that have an impact on mental health and mental illness, and representatives of national stakeholder organizations, such as associations of health professionals


Trail Blazing
The stigma associated with mental illness is often harder to live with than the disease itself.

ROUTE MARKERS

Opening Minds is the MHCC's anti-stigma/anti-discrimination initiative designed to change the attitudes and behaviours of Canadians towards people living with mental illness. Here's what we accomplished in 2009:

Launch
Opening Minds was launched on October 2, 2009 at the top of the Calgary Tower. The Tower's flame was lit to symbolically bring the issue of stigma and discrimination 'out of the shadows forever.'

***Opening Minds* Projects**
The initiative's two initial target groups are youth and health care providers. Youth were chosen because many adults with a mental illness say they first experienced symptoms in their teens. Health care providers were chosen because people living with mental illness say it is often on the front lines that they experience the most discrimination.

Opening Minds is partnering with organizations and communities already working on projects to reduce stigma. In 2009, a national request for projects was issued. About 250 submissions were received. Forty projects *(split equally between youth and health care)* were selected by an impartial panel of Canadian and international experts. The projects are being evaluated for their effectiveness in reducing stigma and their potential to be promoted and implemented nationally.

The workforce was added as *Opening Minds'* third target group in early 2010. It was selected because many employees choose to go untreated rather than risk being labelled as 'unreliable, unproductive and untrustworthy' if they disclose a mental health issue. Meanwhile, every day half a million Canadians are absent from work because of mental health problems. Mental illness also has a direct financial impact on the employer's bottom line and the economy, totalling at least $33 billion per year in lost productivity.

Opening Minds is hoping to establish partnerships with employers actively creating psychologically safe workplaces that foster mental wellness. Their projects will be evaluated, with the goal of reproducing the most effective ones across Canada.

Additional target groups such as seniors, First Nations / Métis and other cultural groups will follow.

Professional Outreach
Opening Minds is working with professional organizations and post secondary schools to reach those working (or preparing to work) in the news media, health care and justice fields. In March 2010, *Opening Minds* partnered with the Alberta Criminal Justice Association for a one-day workshop entitled *Mental Health on the Frontlines of Justice*. The event was held in both Calgary and Edmonton on separate days. In addition to exploring the issues and solutions related to mental health and the law, the purpose was to reduce stigmatizing attitudes in people working within the justice system.

Public Awareness
A public awareness campaign for *Opening Minds* ran from September to November 2009 (in the Globe and Mail, La Presse, MuchMusic, CTV and online) featuring personal stories of hope and recovery.

OPENING MINDS ALSO

- Developed national and international relationships to learn from the successes and failures of other organizations working to reduce stigma and discrimination
- Worked with Statistics Canada to develop a survey that will determine the current attitudes of Canadians regarding mental illness (survey to be conducted in 2010)
- Worked on the development of a Media Advisory Council made up of national news media leaders who will help create media guidelines for writing about mental illness
- Began a project with a Montréal-based research group to look at the language and content used by the news media when dealing with stories about mental illness
- Supported development of The Hallway Group, composed of people who have firsthand experience with mental health issues. They will help steer *Opening Minds'* anti-stigma efforts. *(The group is named for the informal conversations that continue in hallways between formal meetings. These are often considered to be the most productive.)*
- Forged partnerships through the creation of a Mental Health Table which includes members of national health care professional associations
- Worked with various MHCC advisory committee projects related to stigma, including helping to choose members of the MHCC Youth Council and participating in its first meeting

DEFINITION

Stigma is a negative or unfavourable attitude. Another word for stigma is prejudice (pre-judgement). Discrimination is the behaviour or action that results from stigma.


A NEW PATH
The number of homeless in Canada is estimated to be between 150,000 and 300,000 people. Around 25-50% also live with mental illness.
In 2009, the MHCC launched *At Home / Chez Soi*, the largest research project of its kind in the world. The goal is to find the best ways to help homeless people living with mental illness.
FLASHING
SOLID
PUSH BUTTON TO CROSS
C F R

At Home/Chez Soi is using and studying a *Housing First* approach to helping people who are homeless and mentally ill. This means assisting them with finding and paying for housing, and then helping with other challenges such as mental illness and addictions. This approach has worked in other jurisdictions to help people find and keep housing, while also improving their overall health and well-being.

Housing First is being compared to other existing housing and support services currently available in Canada. Participants get to choose where they want to live, and also get to choose the types of services and supports that best meet their individual needs. They must agree to pay up to 30% of their income towards their rent and to meet with a staff member once a week.

More than two thousand homeless people will participate in five cities across Canada. Through random assignment, 1,325 participants will receive tailored housing and support services, and the remaining group will receive the kind of care normally available in their city.

Each city will target specific community needs and sub-populations as follows:

- Vancouver – people with substance abuse and addictions issues
- Winnipeg – urban aboriginal people *(will comprise approximately 70% of the study group)*
- Toronto – ethno-cultural diversity, including non-English speaking immigrants
- Montréal – mental health services provided to homeless people in Québec, including French-speaking new Canadians; a look at social and private housing
- Moncton – the shortage of mental health services in English and French for people in a small city and those in surrounding rural areas

The goal is to find out which services provide the best outcomes so that Canada can lead the world in providing services to homeless people living with mental illness.

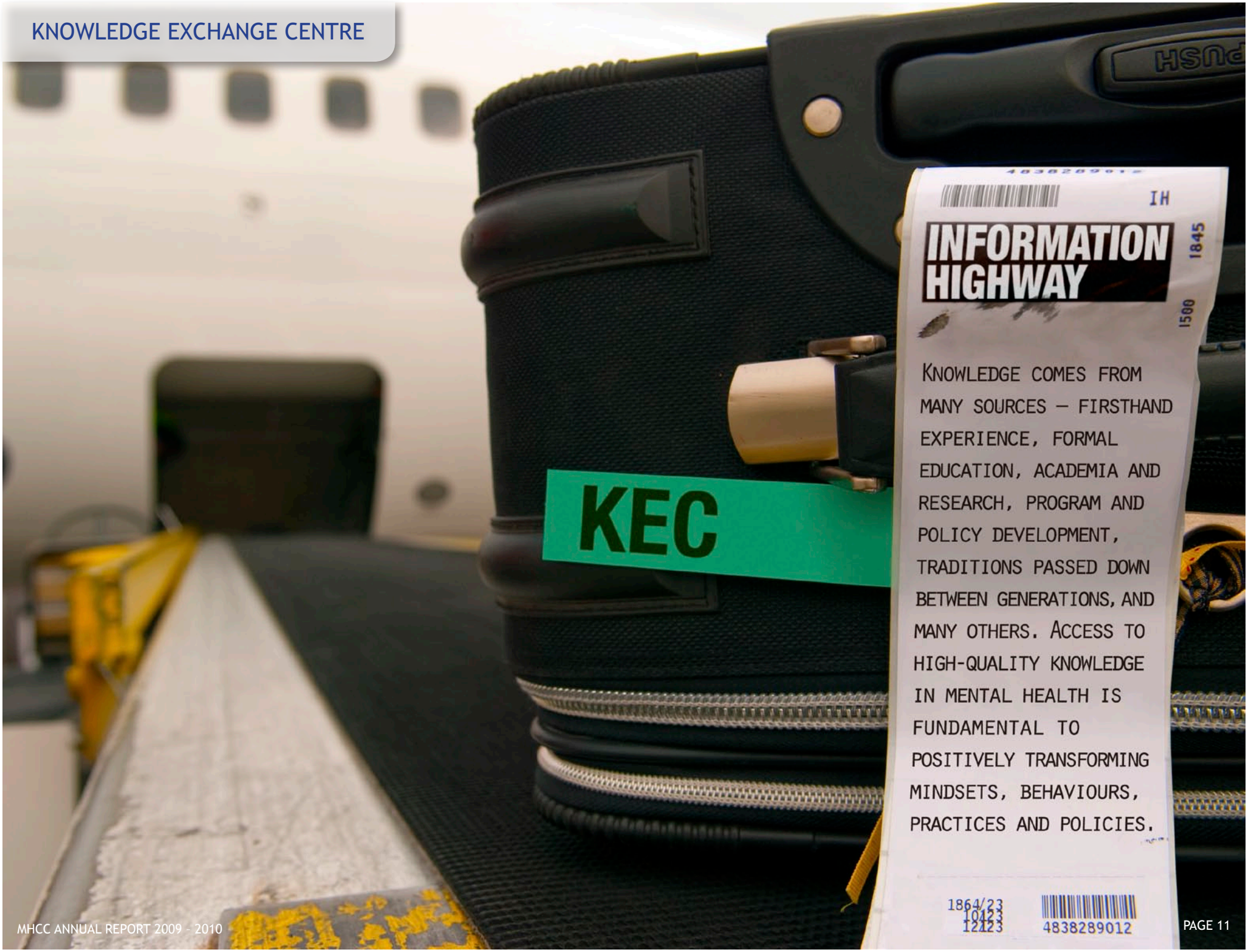
KEY ACCOMPLISHMENTS

- Launched the *At Home/Chez Soi* initiative in each city and nationally on November 23, 2009, resulting in extensive media interest and coverage
- Began providing housing and services in all five sites; as of March 2010, more than 400 participants had been recruited
- Hired service and research staff for all sites
- Created local advisory committees for all sites
- Through partnership with Canadian Institutes of Health Research, provided funding to three complementary research projects, two focused on youth who are homeless and mentally ill, and one focused on the service context
- Established a National Working Group with staff and partners from each city to create linkages between sites, to share information and to provide a forum for problem solving
- Created a Safety and Adverse Events sub-committee responsible for reviewing how critical incidents are handled, and for providing advice and recommendations to assist in preventing similar events in the future
- Established a National Consumer Panel to provide a perspective from people with lived experience in mental health issues and homelessness, and to represent consumer interests related to the project
- Trained 180 people, including team leaders, service providers and researchers, in the Housing First approach
- Registered the projects as a clinical trial and received ethics approval
- Established protocols for data collection, tested and refined data collection tools, and put support contracts in place
- Developed and executed research grants, contracts and service aspects of the project for all sites

FACT

A British Columbia study found that homeless people with severe addictions and/or mental illness, use 33% more health and criminal justice services than do people who have supported housing.

Patterson, M., Somers, J., McIntosh, K., Shiell, A., & Frankish, C.J. (February 2008). Housing and support for adults with severe addictions and/or mental illness in British Columbia. The Centre for Applied Research in Mental Health and Addiction. Retrieved from http://www.carmha.ca/publications/all-publications.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KNOWLEDGE COMES FROM MANY SOURCES – FIRSTHAND EXPERIENCE, FORMAL EDUCATION, ACADEMIA AND RESEARCH, PROGRAM AND POLICY DEVELOPMENT, TRADITIONS PASSED DOWN BETWEEN GENERATIONS, AND MANY OTHERS. ACCESS TO HIGH-QUALITY KNOWLEDGE IN MENTAL HEALTH IS FUNDAMENTAL TO POSITIVELY TRANSFORMING MINDSETS, BEHAVIOURS, PRACTICES AND POLICIES.
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ACCOMPLISHMENTS

The Mental Health Commission of Canada spent this year laying the foundation for the *Knowledge Exchange Centre,* an initiative that will facilitate the development, uptake, adoption and integration of different types of knowledge. In 2009, we:

- Completed an environmental scan of English and French knowledge exchange activities in mental health in Canada. This process allowed us to discover more than 150 mental health-related knowledge exchange activities happening across the country, as well as gave us insight into the gaps, opportunities and added value the Commission can bring to this field of work.
- Completed a review of both scientific and 'grey' literature on knowledge exchange in relation to mental health. The review identified more than 150 relevant articles and documents, most of which have been published over the past four years.

This initial discovery phase enabled the Commission to begin developing a framework for what its *Knowledge Exchange Centre* will bring to Canadians. It also allowed us to explore various forms of technologies, build the infrastructure, develop a variety of plain-language tools and resources, and ensure from the get-go that evaluation processes are built into all levels of our work. We are now turning our attention to taking the steps that will lead us there.

FACT

It takes considerable time and effort to translate knowledge into action. For example, it can take more than 15 years for knowledge to be incorporated into practice and even then, its application is highly uneven.

Reference: Institute of Medicine (2001). Crossing the quality chasm: A new health system for the 21st century. Washington, D.C.: National Academy Press.


RIDING WITH FRIENDS
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MHCC Transit
www.mentalhealthcommission.ca
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Social movements have become one of the fastest growing tools for building support for important issues around the world.

Through its *Partners for Mental Health Program,* the MHCC is committed to creating a grass-roots social movement that will raise awareness for mental health issues through action.

Why A Social Movement?

Because it's time.

And the timing has never been better for mental health to receive the same attention and support as any other health issue. Everywhere the Commission goes, Canadians are eager to help and get engaged. From the workforce to labour unions, health care settings, community groups, governments and the family unit, they want to contribute.

Creating a social movement is no small feat. This is why the past year was spent on gaining a solid understanding of social movements — how they are created, how they function, what makes them thrive, what makes them disappear — and building the foundation for what *Partners* will bring to Canadians.

This is a unique and truly exciting challenge for the MHCC and for all.

"Never doubt that a small group of thoughtful committed citizens can change the world; indeed, it's the only thing that ever has."

Margaret Mead

"Mental health issues will not come 'out of the shadows' until people speak out. Power comes from acknowledgement. Healing comes from action."

Public, online consultation

FACTS

- By 2020, it is predicted depression will become the leading cause of disability worldwide after heart disease.

  World Health Organization

- The number of Canadian children and youth affected by mental illness at any given point in time is 15% or 1.2 million.

  Mood Disorders Society of Canada, Quick Facts: Mental Illness & Addiction in Canada, Third Edition, 2009


MENTAL HEALTH
FIRST AID

Mental Health First Aid (MHFA) is the help provided to someone developing a mental health problem or in a mental health crisis. This first aid is given until appropriate professional treatment is received or until the crisis is resolved.

Mental Health First Aid training shows Canadians how to better manage potential or developing mental health problems in themselves, a family member, a friend or a colleague. The basic MHFA course is available in French and English. It teaches people how to:

- Recognize the signs and symptoms of mental health problems
- Provide initial help
- Guide someone towards appropriate professional help

MHFA Canada was launched in October 2006, and officially joined the MHCC in April 2010. Much work was done within the MHCC before that date to ensure a smooth transition and to plan for the continuing growth of the program. At that time, there were 270 instructors and over 19,000 people trained in mental health first aid across Canada. Those numbers continue to grow. They include members of the public, teachers, nurses, RCMP, transit workers, counsellors, provincial justice workers, human resource managers, social workers and others.

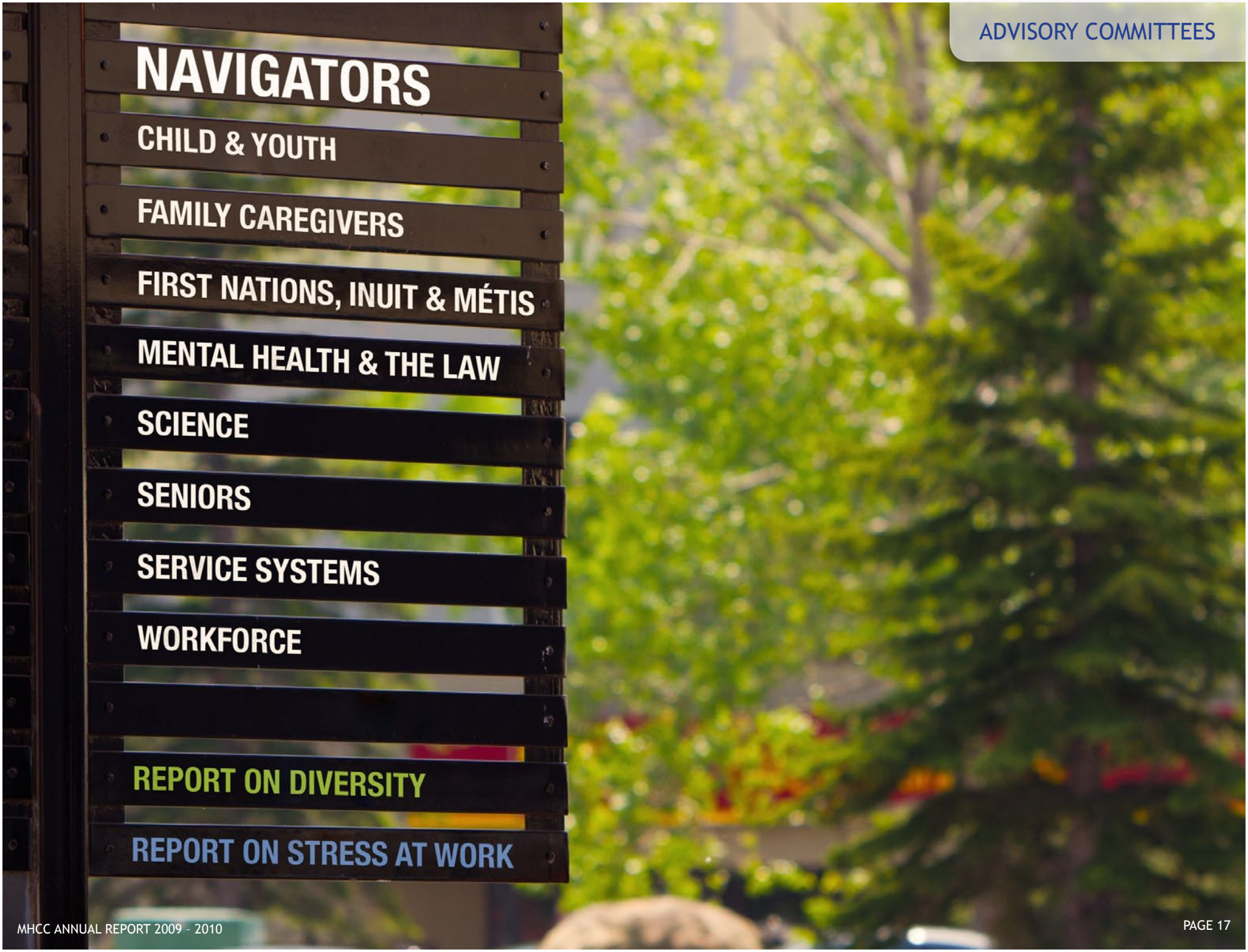
The MHFA initiative also offers instructor training, including an instructor course for adults who interact with youth 12-24 years of age.

For more information, course listings, and to view a related MHFA video, please visit the *Mental Health First Aid Canada web site.*

- MHFA does not teach people to be therapists
- MHFA has been evaluated in several other countries and there are consistent findings: participants show an increase in knowledge, a decrease in stigmatizing attitudes, and an increase in "helping behaviours"
- The MHFA program is available to anyone interested in learning mental health first aid

Several projects related to MHFA are currently under development and include:

- MHFA for Aboriginal Peoples — with a plan to train 24 Aboriginal instructors across all provinces and territories and to have a national Aboriginal Master Facilitator
- Work with universities across Canada to provide and evaluate MHFA training for students and faculty including medical students
- The training of additional instructors who can deliver MHFA in French


NAVIGATORS
CHILD & YOUTH
FAMILY CAREGIVERS
FIRST NATIONS, INUIT & MÉTIS
MENTAL HEALTH & THE LAW
SCIENCE
SENIORS
SERVICE SYSTEMS
WORKFORCE
REPORT ON DIVERSITY
REPORT ON STRESS AT WORK

More than 120 experts from across the country are divided into eight Advisory Committees who are working on various mental health issues in support of the MHCC's key initiatives. There are currently 24 research projects taking place in various provinces.

CHILD AND YOUTH

Seventy percent of adults with mental health issues first developed symptoms before they were 18 years old. The Child & Youth Advisory Committee believes it is important to identify youth at risk and intervene as early as possible. In 2009, the Committee worked on the following projects:

- The Evergreen Framework, a document that will help service organizations and governments in developing policies and plans in the area of child and youth mental health. The document will be released in the fall of 2010.
- The creation of the Youth Council, a group of 17-25 year- olds who have firsthand experience with mental illness. Its role is to represent the voice of young people across all areas of the MHCC's work.
- A School-Based Mental Health and Addictions Services Research Project, which will provide practitioners and policy makers with evidence-based program options for delivery of mental health and addictions services in school.
- The Family Unit Self-Stigma Project, which will address issues of stigma directed inwardly towards self or the family unit. This can result in low self-esteem, isolation, worsening of symptoms and impeding of recovery.
- The Child and Youth Mental Health Knowledge Mobilization Project, which is creating ways of sharing information on topics related to children and youth mental health, to inform and engage youth, as well as those that care for and work with them.

FAMILY CAREGIVERS

The hardships that come with long-term care often affect a caregiver's own well-being. The Family Caregivers Advisory Committee is working on ways to support caregivers. In 2009, it developed the Mental Health Family Link project, a pilot program which matches caregivers with peer volunteers for telephone-based support and information. The committee is currently training volunteers and piloting the program in Toronto.

> "Personally my family has been a huge support through my illness and recovery. As someone who had acute psychosis, my family witnessed me being very ill. This was a very traumatic experience for them and one that they still struggle with dealing with emotionally. Support and care for the family is essential and something that was really lacking in my experience."
>
> *Public online participant*

FIRST NATIONS, INUIT AND MÉTIS

The First Nations, Inuit and Métis Advisory Committee is dedicated to promoting the overall mental health and well-being of Canada's indigenous people. This includes:

- The Cultural Safety and Relational Practice Project, a Canada-wide research project designed to develop educational materials to assist with providing services in a culturally-sensitive manner. Five groups were held to explore consumers' and providers' experiences in these areas. A DVD and other learning materials are being disseminated in Alberta.
- An Ethical Guidelines Project for delivery of frontline services to First Nations, Inuit and Métis Communities. While the guidelines can be applied across the health care and social service fields, the work will focus mainly on mental health and addictions where some of the most vulnerable indigenous people seek support.

MENTAL HEALTH AND THE LAW

The Mental Health and the Law Advisory Committee examines how the legal system affects the human rights of those with mental health problems. In 2009, this included:

- The Evaluation Project on Human Rights and Mental Illness, which will develop and pilot a method of evaluating Canadian legislation relevant to mental health and mental illness. This approach will be applied to samples of mental health legislation from three provinces, and a draft set of human rights accountability standards for mental health services will be prepared.
- The National Trajectory Project, which is completing a case study in Québec, Ontario and British Columbia of those declared not criminally responsible due to a mental disorder. The purpose is to develop an improved understanding of their journeys through the mental health and criminal justice systems. The findings could have implications for improving service delivery, reducing stigma and protecting the public, while also protecting the rights of individuals living with mental illness.
- Development of Guidelines which will influence police training and education in order to improve interactions between people with mental illness and the police. The Police Project is studying consumer experiences with and attitudes toward the police in British Columbia. These findings will be used in consultations with police services across Canada.
- Working with police services to change the practice of listing apprehensions as 'arrests' or disclosing them in criminal records or vulnerable persons' checks. It is now policy in Saskatchewan to prohibit the release of police records when individuals have been apprehended under the Mental Health Act.
- Working in collaboration with the Heads of Corrections on a framework for a National Corrections Mental Health Strategy for Canada. This strategy will be designed to address the complexity and range of services required in both federal and provincial institutional and community settings, as well as the education and training needs of corrections staff.

SCIENCE

The Science Advisory Committee is developing new research models. It also links policy development to scientific research. In 2009, this included:

A Consumer/Peer Research Network to encourage and support consumers in engaging in research projects related to mental health.

Development of a variety of information resources for multicultural mental health for consumers, practitioners, policy-makers and community organizations, including multilingual information on mental health problems and treatments aimed at inpatients.

SENIORS

Mental illness is not a normal part of aging. The Seniors' Advisory Committee works to ensure the mental health needs of seniors are addressed. In 2009, this included:

- Reviewing the 1988 Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders, a major reference document for clinicians in Canada. The Advisory Committee is working to update this document to 2010 standards with the goal of releasing it in November 2010.
- A think tank held in Ottawa in March 2009, which brought together leaders in knowledge exchange, and seniors' mental health and dementia. As a result, an issues and options paper was produced providing recommendations regarding the development of the MHCC Knowledge Exchange Centre as it relates to seniors.

SERVICE SYSTEMS

The Service Systems Advisory Committee provides advice to the MHCC on creating high-performing mental health systems that meet the needs of people living with mental illness. In 2009, this included:

- Working to make peer support an integral part of the mental health system, including a large environmental scan project to get input from people across the country on their experiences with peer support.
- Publishing the report Improving Mental Health Services for Immigrant, Refugee, Ethno-cultural and 'Racialized' Groups, which provides 16 recommendations for service improvement, as well as some examples of how these ideas are being implemented in various parts of Canada.
- Housing and Related Supports Project: A Canada-wide environmental scan to gather information to support the development of a National Housing Strategy. A national reference group, as well as reference groups for all provinces and territories, have been set up.

WORKFORCE

The Workforce Advisory Committee is working on projects to encourage employers and business leaders to make a decisive commitment and take action on how mental health is viewed and managed in the workplace. In 2009, this included:

- Commissioning an update of the report *Stress at Work, Mental Injury and the Law in Canada*, originally published in 2008. This document summarizes court cases and legal findings on psychological health and safety in the workplace. The findings and recommendations will be discussed in September 2010, in Vancouver, at an event with business and union leaders.
- Development of workplace standards for psychological health and safety. At a 2009 consensus meeting, a group of key stakeholders wholeheartedly endorsed the need for a Canadian national standard and recommended the MHCC to pursue this. The standard development organizations, the Canadian Standards Association and the Bureau de Normalization du Quebec have since agreed to a statement of understanding with the MHCC to develop this standard once funding is secured.
- Development of standards of practice for peer support and peer education, including an accreditation process. Based on the Canadian Forces workplace model, this project started in 2009 and became formally associated with the MHCC in April 2010.
- The Sustainable Income and Employment: the Aspiring Workforce Project, which aims to provide the right support for people living with mental health problems / illnesses who want or need to work. The research will review existing practices (such as supported employment, and peer-run / alternative business corporate sector), and will develop a model for disability benefits.
- An Integrated Approach to Mental Healthcare in the Workplace Project, a joint model in development between employers, and consulting physicians and psychologists for preventing mental illness in the workplace.
- The CEO Leadership Guidelines Project is aimed at business leaders and promotes tools for maximizing mental health in the workplace.

REPORT ON DIVERSITY

Immigration is feeding Canada's population growth and Canada is becoming more diverse every year. The mental health needs of this country's immigrant, refugee and ethno-cultural groups are also becoming more apparent.

Through extensive national consultations, a joint report was produced by experts from the MHCC Service Systems Advisory Committee and from the Centre for Addictions and Mental Health. The detailed report contains suggestions about how to improve mental health services for these target groups in Canada.

The report proposes an approach with a focus on prevention, in addition to a better coordination of policy, knowledge and accountability; the involvement of communities, families and people with lived experience in mental health issues; and more appropriate and improved services.

There are also 16 specific recommendations ranging from provincial data collection on mental health needs, to cultural competence training as a standard for all professional care workers.

The next step involves sharing this information with a wide range of stakeholders, especially those who set and change policies in the areas of health and welfare, community services and immigration services. New policies could help create new services to better meet the needs of diverse ethnic groups.

Suggestions resulting from this report will also inform the national Mental Health Strategy being designed by the MHCC.

REPORT ON STRESS AT WORK

The workplace is recognized as an important influence on mental health. There is now an emerging climate of responsibility when it comes to employers ensuring that their workplaces do not hurt their employees' mental health. This kind of injury can have widespread effects, from the health of families to company productivity.

- It is within this context that the report called *Stress at Work, Mental Injury and the Law in Canada: A discussion paper for the Mental Health Commission of Canada* was prepared.
- The report finds there are no set boundaries of liability for mental injury at work, and no standards to measure or assess the risk to mental health within an organization. This means there is currently a lot of uncertainty in this area for both employers and employees.
- There is a need for corporate and social responsibility in defining and clarifying issues that will make it possible to ensure mentally healthy workplaces going forward; for example, to what extent is there "extra" duty of care to vulnerable employees, and how can employers discover such vulnerabilities given privacy issues? What are fair and reasonable management practices?
- The MHCC is hoping that release of this report will stimulate debate and lead to the eventual development of a national standard for psychological safety in the workplace.


POINTS OF INTEREST
THE MHCC
was firing on all cylinders in 2009, working to engage Canadians from coast to coast through symposiums, conferences, roundtables and other activities designed to move mental illness to the forefront of the national agenda.

INTERNATIONAL ROUNDTABLE

Impact of the Recession on the Mental Health of Workers and Their Families

In response to recent events in international financial markets, the Commission along with Human Resources and Skills Development (Government of Canada) hosted an *International Roundtable on the Economic Crisis and Mental Health* in August 2009. The idea was to explore the challenges and opportunities for mental health and well-being within the existing economic climate. In addition to Canada, presenters attended from Australia, Ireland, New Zealand, the United Kingdom and the United States of America.

OTTAWA SYMPOSIUM ON MENTAL HEALTH

In October 2009, the MHCC held a symposium with Ottawa's research and academic community. The aim was to share ideas and develop key research linkages to help strengthen and improve mental health care in Canada. Attendees also included health care workers, policy planners, educators, consumers and caregivers. The Department of Psychiatry at the University of Ottawa, the Royal Ottawa Mental Health Care Group, and the Institute of Mental Health Research of the University of Ottawa were co-collaborators.

INTO THE LIGHT CONFERENCE

In November 2009, the MHCC hosted and co-sponsored the national conference *Into the Light: Transforming Mental Health in Canada*. Held in Vancouver, it brought together experts from around the world to discuss and innovate on issues related to mental health. More than 700 delegates took in numerous presentations and breakout sessions on a range of topics including Canadian mental health law, peer support and stigma. In addition, the Commission launched *Towards Recovery and Well-Being*, the framework document for Canada's first ever mental health strategy. Vancouver Coastal Health and Simon Fraser University were partners.

HEALTH MINISTER VISIT

The Commission welcomed the Hon. Leona Aglukkaq, the Federal Minister of Health, at its head office in Calgary in February 2010. Ms. Aglukkaq spoke with members of the Executive Leadership Team who provided an overview of each initiative and responded to questions about MHCC efforts in the North.


FINANCIAL
STATEMENTS
Read
Year ended
March 31, 2010
Audited by
KPMG
MENU

AUDITOR'S REPORT

To the Board of Directors
Mental Health Commission of Canada

We have audited the statement of financial position of Mental Health Commission of Canada (the "Commission") as at March 31, 2010 and the statements of operations and changes in net assets and cash flows for the year then ended. These financial statements are the responsibility of the Commission's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Commission as at March 31, 2010 and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

KPMG LLP

Chartered Accountants
Calgary, Canada

June 4, 2010

STATEMENT OF FINANCIAL POSITION

March 31, 2010, with comparative figures for 2009

	2010	2009
Assets		
Current assets		
Cash and cash equivalents	$4,548,749	$4,003,846
Contract advances	1,702,611	–
Accounts receivable	979,886	89,791
Deposits and prepaid expenses	201,093	55,402
Investments (note 3)	41,471,051	–
	48,903,390	4,149,039
Long term investments (note 3)	48,583,898	–
Capital assets (note 4)	726,421	814,886
	$98,213,709	$4,963,925

	2010	2009
Liabilities and Net Assets		
Current liabilities		
Accounts payable and accrued liabilities	$3,012,219	$1,179,954
Deferred program fees (note 12)	12,221	–
Deferred contributions – operating (note 5)	32,996,086	2,947,336
	36,020,526	4,127,290
Deferred capital contributions (note 6)	726,421	814,886
Deferred contributions – operating (note 5)	61,403,145	–
Net assets	63,617	21,749
Commitments (note 7)		
Contingency (note 8)		
Subsequent event (note 12)		
	$98,213,709	$4,963,925

See accompanying notes to financial statements

On behalf of the Board:

Mike Kirby

Fern Stockdale Winder

STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS

Year ended March 31, 2010, with comparative figures for 2009

	2010	2009
Revenue:		
Grant income (note 5)	$28,232,329	$7,883,477
Interest income and other income	41,868	21,749
	28,274,197	7,905,226
Expenses:		
Direct client services (note 9)	11,491,768	–
Services	7,441,038	2,357,782
Salaries and benefits	5,565,440	3,102,407
Travel	1,797,912	1,061,489
Meetings and events	820,598	416,520
Materials	512,879	361,732
Rent	301,346	284,352
Amortization	301,348	299,195
	28,232,329	7,883,477
Excess of revenue over expenses	41,868	21,749
Net assets, beginning of year	21,749	–
Net assets, end of year	63,617	21,749

See accompanying notes to financial statements.

STATEMENTS OF CASH FLOWS

Years ended March 31, 2010 and 2009

	2010	2009
Cash provided by (used in):		
Operations:		
Excess of revenues over expenses	$41,868	$21,749
Items not affecting cash flows:		
Amortization of deferred capital contributions	(301,348)	(299,195)
Amortization	301,348	299,195
	41,868	21,749
Net change in non-cash working capital balances:		
Contract advances	(1,702,611)	–
Accounts receivable	(890,095)	638,917
Deposits and prepaid expenses	(145,691)	(15,676)
Accounts payable and accrued liabilities	1,832,265	(532,847)
Deferred program fees	12,221	-
	(852,043)	112,143
Investing:		
Purchase of investments	(90,054,949)	–
Purchase of equipment	(212,883)	(127,444)
Deferred capital contributions	212,883	127,444
	(90,054,949)	–
Financing:		
Deferred contributions	91,451,895	2,932,940
Net increase in cash and cash equivalents during the year	544,903	3,045,083
Cash and cash equivalents, beginning of year	4,003,846	958,763
Cash and cash equivalents, end of year	$4,548,749	$4,003,846
Supplemental information:		
Interest received	$36,802	$21,749

See accompanying notes to financial statements.

NOTES TO THE FINANCIAL STATEMENTS

Year ended March 31, 2010

1. Description of the business:

The Mental Health Commission of Canada (the "Commission") was incorporated on March 26, 2007 under the Canada Corporations Act. The Commission's mandate is to:

(a) To facilitate and animate a process to elaborate a mental health strategy for Canada;

(b) To build a Pan-Canadian Knowledge Exchange Centre that will allow governments, providers, researchers and the general public to access evidence-based information about mental health and mental illness and to enable people across the country to engage in a variety of collaborative activities;

(c) To develop and implement a 10 year initiative to reduce the stigmatization of mental illnesses and eliminate discrimination against people living with mental health problems and mental illnesses; and

(d) To conduct multi-site, policy relevant research that will contribute to the understanding of the effectiveness and costs of service and system interventions to achieve housing stability and improved health and well-being for those who are homeless and mentally ill.

The Commission is registered as a non-for-profit Corporation under the Income Tax Act (Canada) and, accordingly, is exempt from income taxes.

The Commission is funded through a Contribution Agreement dated July 4, 2007 with Health Canada which calls for $5.5 million of contribution to March 31, 2008, a Funding Agreement which calls for $124.5 million over the nine years ending March 31, 2017 and a Funding Agreement which calls for $110 million over the five years ending March 31, 2013. The contributions are subject to terms and conditions set out in the Funding Agreements.

2. Significant accounting policies:

(a) Change in accounting polices:

Effective April 1, 2009, the Commission adopted the Canadian Institute of Chartered Accountants ("CICA") amendments to the 4400 Sections of the CICA Handbook. These amendments eliminate the requirement to show net assets invested in capital assets as a separate component of net assets, clarify the requirement for revenue and expenses to be presented on a gross basis when the not-for-profit organization is acting as principal and require a statement of cash flow. Adoption of these recommendations had no significant impact on the financial statements for the year ended March 31, 2010.

(b) Financial statement presentation:

These financial statements have been prepared in accordance with Canadian generally accepted accounting principles.

(c) Revenue recognition:

The Commission follows the deferral method of accounting for contributions.

Restricted contributions are recognized as revenue in the year in which the related expenses are incurred. Unrestricted contributions are recognized as revenue when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured. These financial statements reflect agreed arrangements approved by Health Canada with respect to the year ended March 31, 2010.

Interest income on investments is recorded on the accrual basis.

Restricted investment income is recognized as revenue in the year in which the related expenses are incurred. Unrestricted investment income is recognized as revenue when earned.

(d) Cash and cash equivalents:

Cash and cash equivalents consist of amounts held on deposit with banks and amounts held in interest bearing mutual fund accounts, maturing within three months.

(e) Capital assets:

Capital assets are recorded at cost and are amortized over their estimated useful life on a straight-line basis using the following estimated useful lives:

Assets	Useful Life
Computer hardware	2 years
IT infrastructure	5 years
Software	2 years
Office equipment	5 years
Furniture	5 years
Leasehold improvements	Over the term of the lease

(f) Financial instruments:

All financial instruments are initially recognized at fair value on the statement of financial position. The Commission has classified each financial instrument into the following categories: held-for-trading

financial assets and liabilities, loans and receivables, held-to-maturity investments, available-for-sale financial assets, and other financial liabilities. Subsequent measurement of the financial instruments is based on their classification.

Unrealized gains and losses on held-for-trading financial instruments are recognized in earnings. Gains and losses on available-for-sale assets are recognized in net assets and transferred to earnings when the assets are derecognized. The held-to-maturity investments and other categories of financial instruments are recognized at amortized cost using the effective interest rate method.

Financial instruments of the Commission consist of cash and cash equivalents, accounts receivable, investments and accounts payable and accrued liabilities. Except where otherwise disclosed, as at March 31, 2010, there are no significant differences between the carrying values of these instruments and their estimated market values.

The Commission's cash and cash equivalents are classified as held for trading, accounts receivable are classified as loans and receivables, investments are classified as held to maturity and the Commission's accounts payable and accrued liabilities are classified as other liabilities.

(g) Use of estimates:

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the period. Significant estimates include the valuation of grants and accounts receivable and the recoverability and useful life of property and equipment. Consequently, actual results may differ from those estimates.

(h) Future accounting pronouncements:

The Accounting Standards Board ("AcSB") has recently issued an Exposure Draft for Not-for-Profit Organizations. The AcSB proposes that Not-for-Profit Organizations select one of the two following alternatives for financial reporting:

- The current Section 4400 "Financial Statement Presentation by Not-for-Profit Organizations" issued by CICA in conjunction with generally accepted principles for private enterprises, or
- International Financial Reporting Standards.

These available standards are applicable to fiscal years beginning on or after January 1, 2012. Current standards will continue to apply until the new standards are issued. Adoption of these new standards is being evaluated and the impact on future financial statements is not known or reasonably estimated at this time.

3. Investments:

Investments consist of fixed income bonds issued by the Government of Canada, crown corporations and provincial governments maturing within three years. These investments have yields ranging from 0.41% to 2.13%.

4. Capital assets:

	Cost	Accumulated amortization	2010 Net book value	2009 Net book value
Computer hardware	$5,619	$5,619	$-	$1,405
IT infrastructure	145,133	56,886	88,247	74,153
Software	186,837	173,521	13,316	63,747
Office equipment	106,688	36,490	70,198	91,536
Furniture	231,698	94,916	136,782	125,555
Leasehold improvements	744,191	326,313	417,878	458,490
	$1,420,166	$693,745	$726,421	$814,886

5. Deferred contributions related to operations:

Deferred contributions include operating funding received in the current period that is related to the subsequent period and restricted contributions relating to the terms and conditions set out in the Health Canada funding agreements. Changes in the deferred contributions balance are as follows:

	2010	2009
Balance, beginning of year	$2,947,336	$14,396
Grants received	119,716,548	10,633,437
Less amount recognized as revenue	(28,232,329)	(7,883,477)
Amounts related to deferred capital contributions	88,465	171,751
Other adjustments	(120,789)	11,229
Balance, end of year	94,399,231	2,947,336
Current portion	32,996,086	2,947,336

	$61,403,145	$–

6. Deferred capital contributions:

Deferred contributions include the unamortized portions of contributed capital assets and restricted contributions relating to the terms and conditions set out in the Health Canada funding agreements.

The changes for the year in the deferred capital contributions balance reported are as follows:

	2010	2009
Balance, beginning of year	$814,886	$986,637
Capital contributions	212,883	127,444
Amounts amortized to revenue	(301,348)	(299,195)
Balance, end of year	$726,421	$814,886

7. Commitments:

The Commission rents premises under operating leases which expire in 2014. Minimum annual rental payments to the end of the lease terms are as follows:

2011	395,235
2012	361,142
2013	361,142
2014	61,980
	$1,179,499

The Commission has entered into contracts for services and research related to its initiative for those who are homeless and mentally ill and contracts related to other projects which support other initiatives which will be completed in 2014. Obligations under these contracts are as follows:

2011	26,466,497
2012	25,357,405
2013	24,484,521
2014	107,760
	$76,416,183

8. Contingency:

The Commission has indemnified its present and future directors, officers and employees against expenses, judgments and any amount actually or reasonably incurred by them in connection with any action, suit or proceeding in which the directors are sued as a result of their service, if they acted honestly and in good faith with a view to the best interest of the Commission. The nature of the indemnity prevents the Commission from reasonably estimating the maximum exposure. The Commission has purchased directors' and officers' insurance with respect to this indemnification.

9. Direct client services:

Direct Client Services pertain to the Commission's research initiative for the mentally ill homeless.

10. Financial instruments and related risks:

Fair values:

With the exception of investments classified as held-to-maturity, the fair value of financial assets and liabilities approximate their carrying amounts due to the imminent or short-term nature of these financial assets and liabilities or their respective terms and conditions.

Risk Management:

The Commission is exposed to the following risks as a result of holding financial instruments:

(i) Credit risk:

The Commission's exposure to credit risk arises from the possibility that the counterparty to a transaction might fail to perform under its contractual commitment resulting in a financial loss to the Commission.

The Commission is exposed to credit risk on its accounts receivable from another organization. Concentration of credit risk arises as a result of exposures to a single debtor or to a group of debtors having similar characteristics such that their ability to meet contractual obligations would be similarly affected by changes in economic, political, or other conditions. The Commission monitors credit risk by assessing the collectability of the amounts. Of the accounts receivable at year end, $99,260 (2009 $72,044) relates to expenditures incurred on behalf of a registered charity, which is in its start-up phase, that supports the mandate of the Commission and had a common chair of the board of directors and chief executive officer for a substantial portion of the year ended March 31, 2010. In addition, $880,626 (2009 $17,096) relates to accrued interest and other receivables. As at March 31, 2010, the Commission did not have a provision for doubtful

accounts due to the nature of the receivables as all amounts will be considered readily collectible.

The Commission is exposed to credit risk on its investments. The Commission manages this risk by ensuring compliance with the requirements of its Funding Agreement with Health Canada. In accordance with this agreement, all investments are in investment grade bonds rated "A" or higher.

(ii) Market risk:

The Commission is exposed to market risk on its investments. The Commission manages this risk by purchasing investments with maturities coinciding with planned cash requirements. The anticipated result of this intention to hold investments to maturity is essentially the elimination of this risk.

(iii) Interest rate risk:

Interest rate risk arises on cash and cash equivalents and investments. The Commission is exposed to interest rate risk due to fluctuations in bank's interest rates.

The Commission does not hedge its exposure to this risk as it is minimal. Every 1% fluctuation in the bank's interest rate results in a $45,487 (2009 – $40,038) annual change in interest revenue.

The Commission is exposed to interest rate risk on its investments. The Commission manages this risk by purchasing investments with fixed interest rates. As the Commission intends to hold its investments to maturity, fluctuations in interest rates will have no impact on how the Commission manages its investments.

11. Capital management:

The Commission views its capital as a combination of cash and cash equivalents and its net assets. Management and the board of directors monitor capital on a frequent basis through reviewing actual to budgeted comparisons.

12. Subsequent event:

On April 1, 2010 the Commission entered into an agreement to facilitate the transfer to the Commission certain personnel, inventory, records and intellectual property pertaining to the Mental Health First Aid Canada program. Included in deferred program fees as at March 31, 2010 is $12,221 pertaining to this program. Effective April 1, 2010 the Commission rented premises for this program with minimum rental payments aggregating $129,575 over the next five years.

BOARD MEMBERS

Lorraine Breault, PhD
University of Alberta, Alberta

Andy Cox
IWK (Izaak Walton Killam) Health Centre, Nova Scotia

Louise de Bellefeuille
Jewish General Hospital, Québec

Patrick Dion
Government of Ontario

Madeleine Dion Stout (Vice-chair)
Dion Stout Reflections Inc, British Columbia

Dan Florizone
Government of Saskatchewan

David S. Goldbloom, MD (Vice-chair)
Centre for Addiction & Mental Health, Ontario

J. Michael Grass
Ontario

Dana Heide
Government of the Northwest Territories

Joan Edwards Karmazyn
CHANNAL (Consumers' Health Awareness Network Newfoundland & Labrador), Newfoundland & Labrador

Michael Kirby (Chair)
Ontario

Jeannette LeBlanc, PhD
Université de Moncton, New Brunswick

Joy Maddigan
Government of Newfoundland & Labrador

Kevin McNamara
Government of Nova Scotia

Morris Rosenberg
Health Canada, Ontario

Mary May Simon
Inuit Tapiriit Kanatami, Québec (Nunavik)

Fern Stockdale Winder, PhD
Saskatoon Health Region, Saskatchewan

Chris Summerville
Manitoba Schizophrenia Society Inc, Manitoba

Arlene Wilgosh
Government of Manitoba

Please note some board members did not serve for the full fiscal year.

ADVISORY COMMITTEE CHAIRS

Ella Amir, **Family Caregivers**
AMI – Québec, Québec

Ian Arnold, MD, **Workforce**
Health, safety, & environmental management consultant, Ontario

Simon Davidson, MD, **Child & Youth**
Children's Hospital of Eastern Ontario, Ontario

Elliot Goldner, MD, **Science**
Simon Fraser University, British Columbia

Steve Lurie, **Service Systems**
Canadian Mental Health Association, Ontario

William Mussell,
First Nations, Inuit & Métis
Native Mental Health Association of Canada & the Salishan Institute, British Columbia

Edward Ormston,
Mental Health & the Law
Consent and Capacity Board, Ontario

Marie-France Tourigny-Rivard, MD,
Seniors
University of Ottawa, Ontario

EXECUTIVE LEADERSHIP TEAM

Jayne Barker, PhD
Director, Policy & Research
Director, At Home/Chez Soi

Louise Bradley
Chief Operating Officer
(President & CEO as of April 1, 2010)

Howard Chodos, PhD
Director, Mental Health Strategy for Canada

Geoff Couldrey
Director, Information Technology
(As of October, 2009)

Michael Howlett
President & Chief Executive Officer

Peter Levesque
Director, Knowledge Exchange Centre
(January – May 2010)

Micheal Pietrus
Director, Opening Minds
Director, Communications

John Stokdijk
Chief Financial Officer

Phil Upshall
Advisor, Stakeholder Relations
Acting Director, Partners for Mental Health (As of January, 2010)

The views represented herein solely represent the views of the Mental Health Commission of Canada.
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Shawna Hickerson
www.auroramotiongraphics.com

"Recovery is beautiful. It is the most wonderful place in the world to be ... living inside my own skin has never felt so good."

Public online participant

"Hope needs to be grounded in the reality that radical change is not only possible, but commonplace in the lives of those of us who have experienced severe mental illness."

Public online participant

JOIN US IN THE JOURNEY.

MENTAL HEALTH COMMISSION OF CANADA

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