TOGETHER WE SPARK CHANGE

ANNUAL REPORT 2011–2012

Mental Health Commission of Canada

Commission de la santé mentale du Canada

TOGETHER WE SPARK CHANGE

IMPROVING CANADA'S MENTAL HEALTH SYSTEM IS A BIG JOB – AND TOO BIG FOR ONE PERSON OR ORGANIZATION ALONE. THE MENTAL HEALTH COMMISSION OF CANADA IS COLLABORATING WITH PEOPLE AND ORGANIZATIONS ALL OVER THE COUNTRY. TOGETHER, WE ARE SPARKING THE CHANGES THAT WILL HELP IMPROVE THE MENTAL HEALTH SYSTEM FOR ALL CANADIANS.

TABLE OF CONTENTS

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The views expressed herein represent the views of the Mental Health Commission of Canada.

Graphic Design by Aurora Motion Graphics Inc.

MESSAGE FROM THE CHAIR, AND PRESIDENT AND CEO

The past year has seen significant progress in the area of mental health reform, which has sparked enormous opportunity for the years ahead.

All of us recognized that if our country was to ever build a better mental health system, it would first need a solid foundation; Canadians would have to start talking openly about mental health and become interested in creating real change. Recently, individuals, governments, corporations and others have begun expressing unprecedented interest in discussing and learning about mental health. More importantly, they want to do more. They want to build a better future for all Canadians.

This year the Mental Health Commission of Canada gave them the blueprint to do that.

Changing Directions, Changing Lives: The Mental Health Strategy for Canada is the first-ever plan of its kind in this country's history, and the Commission's most significant piece of work to date. And it is an opportunity we cannot afford to waste.

The *Strategy* is about promoting mental wellness, preventing mental health problems and suicide where possible, and improving all of the health, social and other systems that comprise our mental health system.

We unveiled the *Strategy* on May 8, 2012. Because it represents such an important opportunity and is the foundation of much of our future work, we wanted to bring attention to it in this annual report.

The plan was informed by the voices of thousands of Canadians, and it is the best chance this country has ever had to improve mental health outcomes for every Canadian.

If you are familiar with the *Strategy*, then you will recognize how the other work of the Commission aligns with the plan's recommendations.

For example, Opening Minds, our anti-stigma initiative, worked to bring programs proven to reduce discrimination to Canadian communities this year.

At Home/Chez Soi, our research project on homelessness and mental health, released a second collection of preliminary findings that pointed toward many successes. The findings also identified challenges that the research teams are working to overcome to ensure we can better help the thousands of Canadians who are living on the streets with mental health problems.

The Commission's Knowledge Exchange Centre initiated a pan-Canadian primary care project, created a training institute for

individuals to learn how to more effectively share knowledge in the field of mental health and accelerate the change that is needed, and launched an awards program to recognize the contributions of programs that are making significant strides in that area.

Our Mental Health First Aid program surpassed another milestone, having now trained more than 50,000 Canadians to spot the signs of a mental health emergency and provide initial help.

Partners for Mental Health launched its inaugural campaign called Not Myself Today with the support of thousands of Canadians and hundreds of organizations.

And our eight Advisory Committees expanded our knowledge of many of the key issues in mental health and informed us on the best ways to address them.

We are grateful for the input and support we received for the *Strategy* and all of our other work from people with lived experience of mental health problems and illnesses, their families, and the vast stakeholder community throughout the country.

Our sincere thanks and appreciation to the Commission's staff for their hard work and unfailing commitment, and to our Advisory Committees for sharing their considerable expertise and for their inspiring dedication.

We are also grateful for the strategic direction and support provided by the Board of Directors. At the time of writing this letter, we are welcoming a new Chair to our Board. David Goldbloom, MD, brings extraordinary knowledge and proven leadership to his new role.

While the release of this *Strategy* marks a historic moment in mental health reform, it also defines the Commission's efforts moving forward. We all have a role to play in fulfilling the recommendations

made in the *Strategy.* The Commission will be doing its part to ensure the *Strategy* reaches as many people, groups and governments as possible, and will encourage them to implemement the recommendations so as to make real changes in the lives of all Canadians.

Together, we are sparking the changes that will redefine mental health care in Canada. We thank you for your interest and support and invite you to continue with us on this journey to ensure that every Canadian can enjoy the best possible mental health.

Michael Kirby
Chair

Louise Bradley
President and CEO

Photos: Jake Wright

A HISTORIC DAY FOR MENTAL HEALTH

On May 8, 2012, the MHCC launched the first-ever strategy to improve the mental health of all Canadians.

Changing Directions, Changing Lives: The Mental Health Strategy for Canada is a comprehensive plan for improving mental health and well-being for everyone, and a blueprint for improving the mental health system as a whole.

More than 250 stakeholders attended the launch in Ottawa, and hundreds more watched the event live via a webcast.

To download the *Mental Health Strategy for Canada,* watch videos from the launch, or to find out how you can put the plan into action, visit the *Strategy* website (http://strategy.mentalhealthcommission.ca/).

(L to R) David Goldbloom, MD, Chair of the MHCC; Louise Bradley, MHCC President and CEO; The Honourable Leona Aglukkaq, Minister of Health; Michael Kirby, Chair of Partners for Mental Health and former Chair of the MHCC; Valerie Pringle, broadcaster and host of the launch; Shana Calixte, Executive Director of the Northern Initiative for Social Action; and Florence Budden, Chair of the Schizophrenia Society of Canada

Photos: Jake Wright

Valerie Pringle

The MHCC's Howard Chodos, PhD, co-author of the *Mental Health Strategy for Canada,* speaks to journalists

David Goldbloom

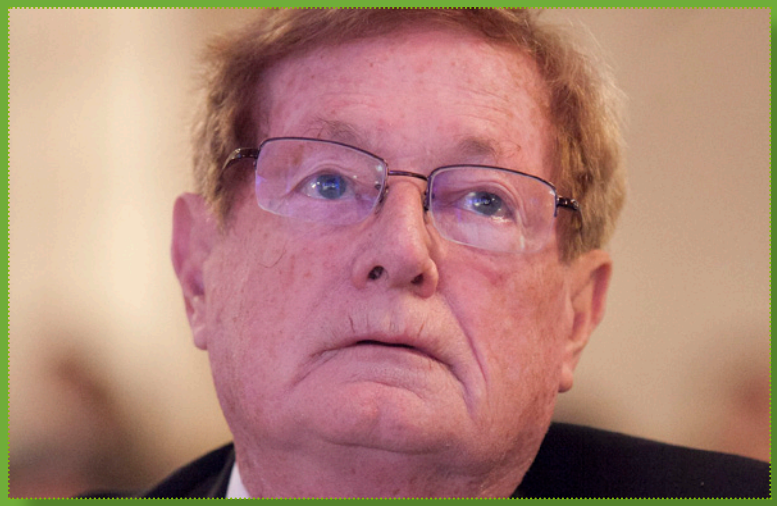
Louise Bradley

(L to R) Leona Aglukkaq, Louise Bradley, Shana Calixte and Florence Budden

Leona Aglukkaq (L) and Louise Bradley

Shana Calixte

Stakeholders assembled in Ottawa for the launch of the first-ever mental health strategy for the country



The Honourable Wilbert Keon, O.C., Co-chair of the Standing Committee of the Senate that produced the landmark report on mental health, *Out of the Shadows at Last*

Leona Aglukkaq

(L to R) Michael Kirby, Valerie Pringle, Leona Aglukkaq and Louise Bradley

(L to R) Lisa Crawley-Beames, President of the Canadian Federation of Mental Health Nurses; Don Wildfong, Nurse Advisor, Policy & Leadership, Canadian Nurses Association; and Fred Phelps, Executive Director of the Canadian Association of Social Workers

(L to R) Lawrence Green, CFO of the MHCC; Former MHCC Board member James A. Morrisey; George Weber, CEO of the Royal Ottawa Mental Health Centre; and Rachel Bard, CEO of the Canadian Nursing Association

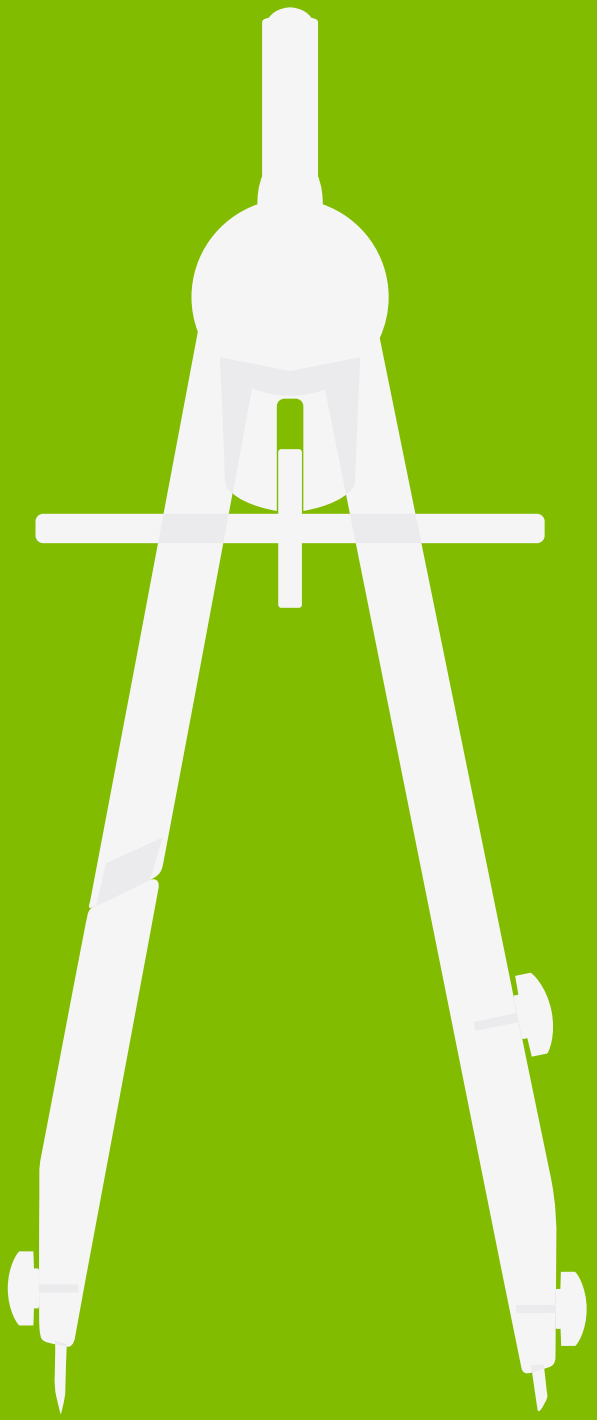
(L to R) Kelly Masotti, Manager, Public Affairs, Canadian Psychiatric Association; the MHCC's Francine Knoops; and Fiona MacGregor, MD, 2011- 2012 President, Canadian Psychiatric Association

Stakeholders assembled in Ottawa for the launch of the first-ever mental health strategy for the country

Florence Budden

Michael Kirby

MENTAL HEALTH STRATEGY FOR CANADA



MENTAL HEALTH STRATEGY FOR CANADA

WE NEED TO DO BETTER WHEN IT COMES TO MENTAL HEALTH. THIS IS A JOB FOR EVERYONE. THE MENTAL HEALTH COMMISSION OF CANADA IS PARTNERING WITH PEOPLE AND ORGANIZATIONS ACROSS THE COUNTRY. TOGETHER, WE HAVE CREATED A BLUEPRINT FOR CHANGE.

WHY CREATE A STRATEGY?

Canada needed a plan to improve a mental health system that is not working well. The purpose of the *Mental Health Strategy for Canada* is to help improve mental health and well-being for all people living in Canada, and to create a mental health system that can truly meet the needs of people of all ages living with mental health problems and illnesses and their families. The *Strategy* draws on the advice of thousands of people across the country, and its six Strategic Directions contain more than 100 recommendations for action.

RELEASED IN MAY 2012 TO GREAT ACCLAIM IN THE MENTAL HEALTH COMMUNITY AND WIDESPREAD MEDIA ATTENTION, *CHANGING DIRECTIONS, CHANGING LIVES: THE MENTAL HEALTH STRATEGY FOR CANADA* IS SPURRING ALL STAKEHOLDERS TO STRENGTHEN THEIR EFFORTS TO BRING ABOUT CHANGE.

The *Strategy* team at the launch of the *Mental Health Strategy for Canada* in Ottawa on May 8, 2012. (L to R) Susan Lynn Hardie, PhD, with Solas, Barbara Neuwelt, Howard Chodos, PhD, Donna Lyons, Mary Bartram, Louise Lapierre and Francine Knoops. Missing from the photo: Sarah Gosling.

Jake Wright

Work on drafting the first-ever *Mental Health Strategy for Canada* was completed in 2011–12. The *Strategy* team held targeted focus groups on a draft of the *Strategy* in the summer of 2011 and it was extensively revised based on the feedback received. During the fall, input from National Aboriginal Organizations was sought to shape the *Strategy's* recommendations on First Nations, Inuit and Métis mental health. During this period, the *Strategy* team also incorporated additional input from stakeholders, including the Provincial-Territorial Reference Group that had been set up to enable governments to review and offer strategic advice on the *Strategy* as it developed, as well as from the Commission's Advisory Committees. The final draft was approved by the MHCC's Board of Directors at the end of March.

The *Strategy* builds on the many excellent initiatives already underway across the country and reflects the findings of the many initiatives and projects undertaken by the MHCC since its inception. The *Strategy* reflects the concerns and aspirations of people from every part of the country. It provides a blueprint that is adaptable to the circumstances of every region and allows people from coast to coast to coast to become involved in bringing about change.

“As a result of my participation I realized I could sit and wait for change to happen or as a caregiver, do something. Since then, I’ve become much more proactive. I’m part of an advocacy committee. I’m working with different organizations. To make life better, I’m trying to make the world a bit better.”

Louise Boulter, family caregiver involved in a focus group session on the draft *Strategy*

The recommendations in the *Mental Health Strategy for Canada* are organized under six Strategic Directions:

1. Promote mental health across the lifespan in homes, schools and workplaces, and prevent mental illness and suicide wherever possible.
2. Foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights.
3. Provide access to the right combination of services, treatments and supports, when and where people need them.
4. Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners.
5. Work with First Nations, Inuit and Métis to address their mental health needs, acknowledging their distinct circumstances, rights and cultures.
6. Mobilize leadership, improve knowledge, and foster collaboration at all levels.

ENSURING SUCCESS

Setting out a plan, no matter how good, is never enough on its own. It will take time to implement the recommendations in the *Strategy*, and it will take sustained commitment and leadership at many levels.

The impact of the *Strategy* needs to be measured over time and reviewed carefully after five years to assess the progress that has been made.

The *Strategy* proposes an initial set of indicators that can be used to do this, and calls for the development and implementation of a long-term plan to strengthen Canada's capacity to track the overall mental health and well-being of the population.

In addition, a case for investment backgrounder (http://strategy.mentalhealthcommission.ca/about/case-for-investment/) was released alongside the *Strategy*. It outlines why investments in mental health in Canada make financial sense, drawing on a larger study commissioned by the MHCC that will be released later in 2012.

To ensure the success of the launch itself, the team worked with a core internal group to develop a launch and dissemination plan for the *Strategy* that included organizing briefings with governments, key stakeholders and the media.

The MHCC created a website for the *Strategy* (http://strategy.mentalhealthcommission.ca/) where visitors can download the document, watch videos, hear what stakeholders are saying about the plan, and learn how they can put it into action.

ADVANCING THE *MENTAL HEALTH STRATEGY FOR CANADA*

Changing Directions, Changing Lives provides an opportunity for everyone's efforts – large and small – to contribute to change. It will be up to people in each region of the country and at every level of government to respond to the *Strategy's* recommendations, in keeping with their particular circumstances. Since there is no one body or government that has responsibility for implementing the *Strategy,* it will take a coordinated effort over time by all levels of government, stakeholders, people with lived experience, families, and others to bring about the changes recommended in the *Strategy*.

In its role as catalyst, the MHCC is planning and executing individual provincial and territorial launches of the *Strategy* to help inform stakeholders across the country, and engaging in conversations with different jurisdictions and sectors about how best to contribute to moving the *Strategy* forward.

Work on developing the *Strategy* has paralleled the development of plans and strategies in many provinces and territories, as well as within federal departments and agencies. The influence of the *Strategy* can already be seen in the way that the common themes and priorities contained in these plans are aligned with those in the *Mental Health Strategy for Canada*.

The MHCC also contributed to the development of some provincial mental health strategies, offering strategic advice and helping to provide expert input. It is very encouraging that a number of provinces have committed resources in recent budgets to implementing their new plans.

OPENING MINDS

LABELS ARE FOR JARS AND FOLDERS—NOT PEOPLE WITH MENTAL HEALTH PROBLEMS AND ILLNESSES. THE MENTAL HEALTH COMMISSION OF CANADA IS WORKING TO CUT THE STIGMA MANY PEOPLE EXPERIENCE. CHANGING HOW WE SEE MENTAL ILLNESS—NOW THAT'S SOMETHING WORTH STICKING TO.

OPENING MINDS

WHY TACKLE STIGMA?

The stigma around mental health problems and illnesses prevents many Canadians from seeking help.

Opening Minds is the MHCC's anti-stigma initiative. Its goal is to change the attitudes and behaviours of Canadians towards those living with a mental health problem or illness. As part of its work, the initiative is evaluating dozens of anti-stigma programs across the country, and working with a network of partners to share the most successful of these programs with communities and stakeholders across Canada.

OPENING MINDS IS REACHING PARTNERS ACROSS THE COUNTRY AND HELPING THEM TO IMPROVE ANTI-STIGMA PRACTICES AND PROGRAMS.

Rivian Weinerman, MD, (R) from British Columbia leads a day-long anti-stigma workshop for family physicians at their annual conference in Montréal. The workshop was evaluated by Opening Minds and results showed it is successful in reducing stigma.

Amanda Tétrault

REDUCING STIGMA WITH PROVEN PROGRAMS

Opening Minds continued its evaluation work this year to identify Canadian programs (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Programs_province_Aug_2011.pdf) that are successful at reducing stigma so they can be replicated elsewhere. At the same time, the initiative is using the research results to help all partners make their programs more effective.

The programs being evaluated are geared toward youth, the workforce, health care providers and the media. To be eligible for evaluation, all required a contact-based education component, which means the audience has exposure to someone who has recovered from a mental illness or is managing their illness. Contact-based education has already been shown internationally to be effective at reducing stigma.

REDUCING STIGMA AMONG YOUTH

One of the programs identified by Opening Minds as successful in reducing stigma among youth is led by the Durham TAMI (Talking About Mental Illness) Coalition based in Ontario. In February 2012, Opening Minds worked with the Coalition to bring the TAMI program to Yellowknife, where it was delivered to every grade 8 student in the city. Discussions are now underway to explore adapting the TAMI program for delivery throughout Canada's northern territories.

TESTING FOR STIGMATIZING ATTITUDES

Opening Minds, in partnership with the Canadian Psychiatric Association, created a quick online test for physicians to determine whether they have a hidden bias against people with mental illnesses. The test usually shows individuals have more stigmatizing attitudes than they had predicted. The hope is that the test results will motivate doctors to take an online anti-stigma course (see below).

A similar test was created for workplace executives and human resources personnel to reveal whether they hold stigmatizing attitudes. This test can also be used among employees.

> “The citizens of Canada are being hugely served by what [Opening Minds and the MHCC] are doing.”
>
> Patrick Corrigan, PhD, Institute of Psychology, Illinois Institute of Technology and a leading international expert on stigma

REDUCING STIGMA AMONG HEALTH CARE PROVIDERS

People with mental health problems and illnesses say some of the most deeply felt stigma they experience comes from health care providers.

The MHCC and other partners developed a web-based continuing medical education program (http://www.cma.ca/stigma) for family physicians and specialists to help them understand and combat the stigma surrounding mental illnesses. The partnership involved Opening Minds, the Mood Disorders Society of Canada, the Canadian Medical Association, Memorial University, Bell, North Bay Regional Health Centre, the Canadian Psychiatric Association, and AstraZeneca Canada.

The program is the culmination of years of research and roughly based on a promising program for family doctors in British Columbia, which is now being evaluated by Opening Minds. In addition to contact-based education to help increase physicians’ understanding of the needs of patients with mental health problems, it includes tools and resources so doctors have more confidence and fewer negative attitudes when treating patients with mental health problems.

The program has been accredited by the College of Family Physicians Canada and the Royal College of Physicians and Surgeons of Canada.

HELPING TO REDUCE STIGMA AMONG PHARMACY STUDENTS

The University of Saskatchewan, Dalhousie University, and Memorial University were each using a similar method of contact-based education to reduce stigma among pharmacy students, and partnered with Opening Minds to evaluate this approach. Results show it is helping to make students more comfortable and confident in working with clients who have a mental health problem. Opening Minds hopes to work with partners to help expand this program to other pharmacy schools.

MEDIA REPORTING ON MENTAL ILLNESS

Research continued this year to determine how the media reports on mental health problems, and whether the media’s reporting is perpetuating negative stereotypes.

Opening Minds has initiated a media monitoring study. A research team at the Douglas Mental Health University Institute/ McGill University has collected and analyzed more than 11,000 Canadian news reports from 2005–2012 for its study on media reporting and mental illness.

The reports were culled from French and English newspapers, radio and television broadcasts, and the internet.

Findings from the research will better inform how we approach the media regarding mental health issues, and help lead the creation of mental health guidelines for the media.

The lead researcher on the media study, Robert Whitley, PhD, was one of the experts who led a CIHR Café Scientifque (http://www.cihr-irsc.gc.ca/e/34951.html) in Montréal in November. The discussion was about the media representations of mental health and mental illness in Canada. Mike Pietrus, Director of Opening Minds, and Heather Stuart, PhD, the senior advisor to Opening Minds, also participated, along with André Picard, public health reporter at the Globe and Mail.

In addition, anti-stigma symposia were held with journalism students at King's College, UBC and Ryerson University to make them aware of how their future reporting work could perpetuate stigma. Presenters included journalists, researchers and individuals who have experienced stigma first-hand.

CREATING NEW PARTNERSHIPS

Opening Minds continued to forge new partnerships with corporations, health care providers, educators and others. The initiative is now working with 80 partners, an increase of 30% over the previous years and the number of partners continues to grow. They are working together to expand the reach of anti-stigma programs across the country.

A WORLD FIRST IN STIGMA RESEARCH

Opening Mind's senior consultant, Heather Stuart, PhD, was appointed the world's first chair in anti-stigma research. The position at Queen's University was created by Bell Canada.

INTERNATIONAL ANTI-STIGMA CONFERENCE

Under the leadership of Opening Minds, the MHCC and the World Psychiatric Association Scientific Section on Stigma and Mental Illness developed plans to host the 5th international anti-stigma conference in Ottawa in June 2012. The conference, called Together Against Stigma: Changing How We See Mental Illness, received more than double the number of abstracts of previous international stigma conferences, as well as more than triple the number of registrations. Opening Minds also secured award-winning actress Glenn Close and members of her family as keynote speakers.

ADVANCING THE *MENTAL HEALTH STRATEGY FOR CANADA*

Changing Directions, Changing Lives: The Mental Health Strategy for Canada calls on all Canadians to reduce stigma and uphold the rights of people living with mental health problems and illnesses. Through its evaluation and promotion of anti-stigma programs, and its work to implement programs directed at several target populations, Opening Minds is already helping to advance the *Strategy*.

Read a validation study (http://www.biomedcentral.com/1471-244X/12/62/abstract) led by Opening Minds on the development and psychometric properties of a new scale to measure stigma among health care providers.

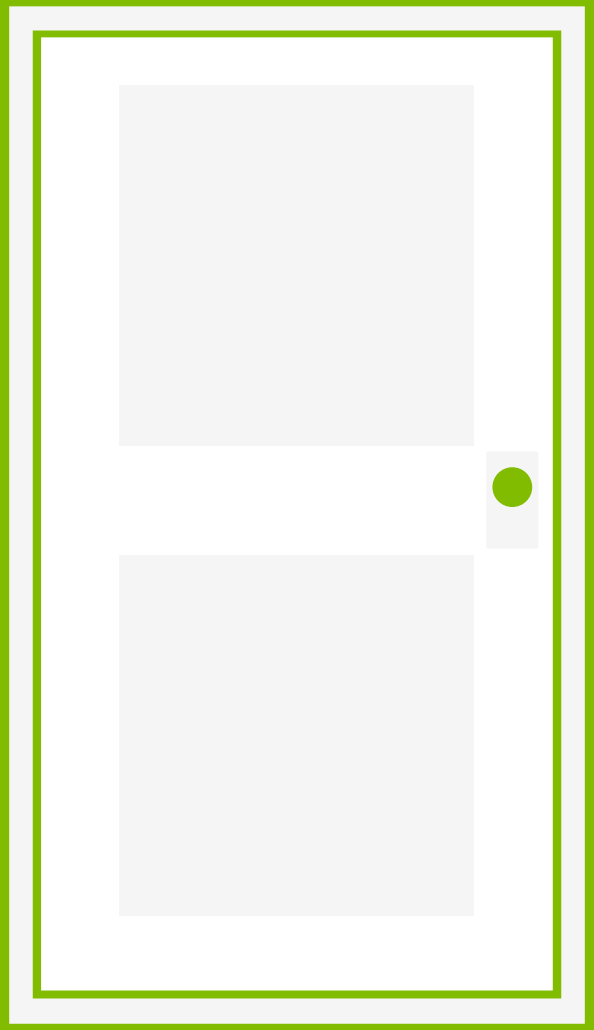
Read evaluation results (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Annual_Report_2012/Quantitative_Analysis_MI_Addictions_Impact_Stigma_ENG.pdf) of Ontario's Central Local Health Integration Network (LHIN)anti-stigma training program for health care workers.

Read evaluation results (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/opening%20minds/OM_Dec5_report_ENG.pdf) of the Central LHIN anti-stigma training program's usage among health care workers in BC's interior region.

Read evaluation results (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Annual_Report_2012/Opening_Minds_at_University_Kings_College_ENG.pdf) of an anti-stigma symposium at the University of King's College.

Watch videos (http://www.mentalhealthcommission.ca/English/Pages/media_symposium_videos.aspx) of presentations at the University of King's College media symposium.

AT HOME / CHEZ SOI



AT HOME / CHEZ SOI

HAVING A HOME CAN OPEN THE DOOR TO RECOVERY FOR SOMEONE WITH A MENTAL HEALTH PROBLEM OR ILLNESS. THE MENTAL HEALTH COMMISSION OF CANADA'S RESEARCH DEMONSTRATION PROJECT IS PROVIDING HOMES, SUPPORTS AND SERVICES TO ABOUT 1,000 CANADIANS SO WE CAN LEARN HOW TO BEST SUPPORT THIS VULNERABLE POPULATION.

WHY FOCUS ON HOMELESSNESS?

Homelessness in Canada is reaching epidemic proportions and there is an increasing focus on the link with mental health. It is estimated that 25-50% of people who are homeless also have a mental illness.

The At Home/Chez Soi project was established to delve into this major societal issue and help come up with some possible solutions. The project is based on a Housing First approach which entails first providing people with a place to live, then helping them with other physical and mental health issues. Projects are taking place in five Canadian cities: Moncton, Montréal, Toronto, Winnipeg and Vancouver.

Despite the very real challenges that come with this bold initiative, lives are changing, and important research is being compiled and shared.

THE AT HOME/CHEZ SOI PROJECT IS HOUSING AND PROVIDING SERVICES TO CANADIANS IN FIVE CITIES, HELPING SOME OF THE MOST VULNERABLE PEOPLE IN SOCIETY.

At Home/Chez Soi project workers from across the country meet in Vancouver for a training event.

Andriy Mishchenko

ACHIEVING OBJECTIVES

The project achieved 100% enrolment during the last fiscal year, providing housing to more than 1,000 people. More than 260 landlords and property management companies, mostly from the private sector, were engaged as partners.

Participants met regularly with research staff, and through these meetings contributed to the body of research being created. Participants in the Housing First interventions received support in a number of areas including housing, mental health, physical health, education, employment and community connections.

RESEARCH AND RESULTS

Crucial to the success of the project is ensuring project support teams and partners are following established research and service standards. Visits to each of the cities by project leaders this year indicated a high degree of adherence to the required standards. In addition, a significant training event held in Vancouver in 2011 helped staff to further develop related skills and learn how to cope with challenges.

Data collection was ongoing and confirmed that the project has met a major goal of enrolling people with some of the highest needs. New research tools were developed, such as an "Observer-Rated Housing Quality Scale," which helps assess the quality of housing received based on a set of common characteristics.

The At Home/Chez Soi *Early Findings Report Volume 2* (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/AtHome-ChezSoi/At_Home_Early_Findings_Report_Volume%202_ENG.pdf) was published in January. The report includes general statistics about the study population. For example, in addition to living with a mental health problem or illness, more than 90% of participants have at least one chronic physical health problem, ranging from back problems (52%) to Hepatitis B or C (25%).

The report also has a particular focus on the current outcomes related to the Housing First approach. One finding is that across the project, 68% of housed participants are still in their first unit; 24% are in their second unit; 6% are in their third unit and just over 2% are in their fourth or fifth units. Participants were re-housed for various reasons including eviction or risk of eviction, hospitalization or incarceration. In some cases, the participant may have requested a move if the current apartment did not meet his or her needs.

> "If anything they're being looked after better than regular tenants because there's all that team behind them."
>
> Landlord speaking about experiences with At Home/Chez Soi tenants

SHARING INFORMATION

One of the main goals of this project is to collect and share research results. Related activities in the fiscal year included presentations about the project across the country, the publication of peer-reviewed articles, the facilitation of media interviews, a unique photo exhibit by Winnipeg participants, and the creation of a web-based documentary video project (http://athome.nfb.ca/#/athome) in partnership with the National Film Board of Canada (NFB).

The NFB project, slated for launch in May 2012, was designed to reflect the successes and challenges of the At Home/Chez Soi initiative. Its format allows viewers to meet the inspiring people who are part of the research project, and highlights the ongoing successes and challenges of project participants. People can view regularly-released short videos, and read statistics and a blog.

Project participants continued to be key contributors to the success of At Home/Chez Soi over the past year. For example, members in Vancouver developed a Speaker's Bureau whereby participants volunteered to share their insights and experiences by taking part in media interviews or other speaking opportunities.

Established communities of practice in the areas of service provision, peer support and housing provided a forum for discussion of best practices, and for raising actual or potential issues.

DEMONSTRATING SUCCESSES

The impact of this project over the past year has become more visible. The project was listed as one possible reason for the decrease in the number of homeless people in Vancouver during that city's 2011 count.

International attention has focused on the project and resulted in outcomes such as the establishment of a similar program in France, based on At Home/Chez Soi research protocols. A visit by an Australian service provider produced a report that cited the benefits of this project in Canada.

The past year also saw the ongoing development of innovative local partnerships, including a link with Corrections Canada in Moncton to help develop vocational opportunities for At Home/Chez Soi participants.

PLANNING FOR THE END OF THE RESEARCH PROJECT

Funding for At Home/Chez Soi ends in March 2013. As such, the project's team leaders have been planning for the transition of hundreds of participants from the research project to ongoing housing and service supports.

It is hoped that as many participants as possible will be able to maintain their current housing or move into different housing. Senior MHCC staff continued to work with partners to identify ways to help with the overall transition process. In Moncton for example, the provincial government agreed to continue funding Assertive Community Treatment (ACT) care for the project participants in that city. (ACT is designed to help people with serious and persistent mental health needs and high supports needs.) Similar solutions are being considered in each of the jurisdictions.

The At Home/Chez Soi team produced several reports and publications this year, such as:

A scientific paper (http://bmjopen.bmj.com/content/1/2/e000323.full) about how the At Home/Chez Soi project is being conducted.

A document (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Annual_Report_2012/AtHome_PSW_CoP_Discipline_Summary_ENG.pdf) outlining the guiding principles and philosophies of peer support workers in the project.

A scientific paper (http://www.springerlink.com/content/k3t6652t7n71198m/?MUD=MP) on interviewing methods related to people with mental health problems and illnesses.

ADVANCING THE *MENTAL HEALTH STRATEGY FOR CANADA*

Changing Directions, Changing Lives: The Mental Health Strategy for Canada calls for an increase in access to housing and supports for people living with mental health problems and illnesses, and in particular for an expansion of approaches such as Housing First for those who are homeless.

At Home/Chez Soi is testing the Housing First model in five cities across the country and the *Strategy's* recommendations are fully aligned with this work. One example is that the model works from a recovery orientation which is premised on participant choice and includes a strong role for peer specialists. There are many other examples which demonstrate some of the *Strategy's* recommendations being put into practice and resulting in positive outcomes.

AT HOME / CHEZ SOI

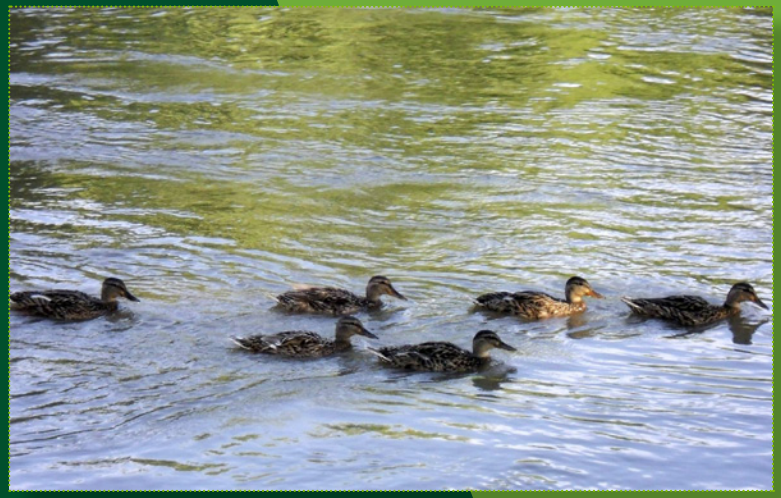
A dark hallway or a bright ball of string; the simplest things can take on significant meaning depending on your perspective.

That was the case this year for some participants in the At Home/Chez Soi project in Winnipeg. Focusing the Frame gave them the opportunity to visually document their experiences. Supplied with digital cameras and a few photography lessons, the men and women turned their lenses on their surroundings and captured a diverse range of people, places and things.

Focusing the frAme

They are for the most part ordinary pictures, but made extraordinary by the words that the participants wrote to accompany them.

Many of the photos went on display at an art exhibit in Winnipeg in the fall of 2011.



FAMILY

Having a mental illness always kept me apart from my family. Even when I was young it was always like I wasn't really together with them. I could be alongside them, but I couldn't be one of them.

My mental illness and a bad drinking problem meant that when I got older I lost my kid. I had another one later and I didn't get to see him either.

Now that I've got a place of my own, I don't drink anymore, I feel so much better, and I get to see my kids. That never would have happened if I didn't get into the At Home/Chez Soi program.

Anonymous

MY KITCHEN

I love to cook. On the street it's hard to get a decent meal. Now my fridge is full and I can choose what and when I eat. I'm so much healthier now, and I get so much satisfaction in doing something I love to do. I can even invite people over for a meal. Beats the hell out of a food kitchen.

Anonymous

STRINGS

The name “chaos theory” comes from the fact that the systems that the theory describes are apparently disordered. But Chaos Theory is really about finding the underlying order in seemingly random data.

The “butterfly effect” is a sensitive dependence on initial conditions. Just a small change in the initial conditions can drastically change the long term behaviour of a system...

I am the system.

Jackie B.

GEESE

Fight or flight. It is always my way to take flight.

Run away, far far away. Avoidance is not always the best way to handle things.

Jackie B.

MAN ON THE WALL
(into the light)

This picture tells me that when something gets in your way you can let it or you can move on. It helps me understand that I have a choice.

Bob B.

MARKER

I wish life had direction markers, it sure would be a lot easier.

Contessa P. H.

SUNSHINE

This young lady [a peer support worker] always brightens my day with her youthful spirit.

Caring, sharing and willing to learn, she can be a ray of sunshine on a cloudy day.

Bob B.

THE VIEW FROM MY CLASSROOM

This is what I see when I look out of my classroom window. The biggest thing the At Home/Chez Soi project has given me is options. When you don't have a home you're just trying to survive, you wouldn't even think about going back to school. Now I'm getting my grade twelve. All I used to look at was dirty streets, shelters, and food kitchens.

Anonymous

GOOD ENOUGH TO EAT

To you this might just look like the food from a back yard barbecue and it is.

However, when I was on the street I didn't know anything about where to get food and I was all alone in the world literally. None of my family or my friends would speak to me, let alone feed me. I went from 170 lbs., which is my normal weight, to 120 lbs in three months.

I quite likely would have died if I hadn't been rescued by the At Home project. Thank you for saving my life.

Joe H.

LIVING ROOM

This is my living room. It's kind of plain and small, but it is very cozy for me and the dogs. It's a very nice place...compared to another place I used to sleep, it's a castle.

Mike E.

THUNDERBIRD HOUSE

This is where I work being a Firekeeper or Scabe' and taking care of the Sweat Lodge. You put the Grandfathers (large stones) into the fire pit and light a fire over them to get them red-hot. Then you bring them into the sweat as many at a time as the Lodge keeper wants.

When you don't have a home you can't get a job. Nobody is going to hire you if you don't have a place. They can't even get a hold of you because you don't have a phone. Now I've got both and don't just get to work, I get to do something that I want to do.

Anonymous

HALLWAY

Long.

Dark.

Endless.

Unknown.

Too many doors.

Panic.

Stand and stare. Terrified.

My At Home/Chez Soi Intensive Care Worker Claudette gently guides me into Life.

Jackie B.

SPLASH

This reminded me of my Panic Attacks. Everything was fine and then all of sudden it was like a wave hitting the shore and my emotions would just go crazy. Since I got in the At Home program I go to sweats and I talk to the Elders and I don't even have to take any medication anymore. It's a lot better than taking a bunch of pills.

Anonymous

TALL BUILDING

When I took this picture it reminded me of how bad my addiction to alcohol was. It felt like I had to be Superman and leap tall buildings with a single bound to get rid of it. At Home gave me the opportunity to deal with that addiction and I don't drink at all anymore. I decide what goes into my body now. Alcohol doesn't decide for me.

Anonymous

FROG WAGON, ST. PIERRE

(Picking Medicine)

We went picking medicine near St. Pierre where I saw this giant frog. It was the first time in a long time that I did something with a group of others, and it made me feel happy inside.

Bob B.

BAGGAGE

I have carried bags that look much nicer than garbage bags... and yet people stare.

I know they know.

I could see it.

I've carried guilt and shame in those bags. They get pretty heavy.

Jackie B.

SLEEPING BAG

How warm, soft, and clean is your bed going to be tonight? You might want to think about the person that sleeps on this one when you crawl in there.

Joe H.

SCHOOL

This is the university that I got my degree from and subsequently worked at for a number of years before I became ill. It just goes to show that not all the people on the street lack education, skills, or a good work history. So remember, if you're looking at this it could have just as easily been you!

Joe H.

KNOWLEDGE EXCHANGE CENTRE

KNOWLEDGE EXCHANGE CENTRE

CHANGE CAN BEGIN WITH A SINGLE CONVERSATION, SO THE MENTAL HEALTH COMMISSION OF CANADA WANTS TO GET EVERYONE TALKING. IT'S HELPING RESEARCHERS, SERVICE PROVIDERS, PEOPLE WITH MENTAL HEALTH PROBLEMS AND ILLNESSES, CAREGIVERS, AND OTHERS TO SHARE WHAT THEY KNOW AND EXCHANGE IDEAS ABOUT MENTAL HEALTH. BY NURTURING THESE CONVERSATIONS, CHANGE CAN TAKE ROOT.

WHY DO KNOWLEDGE EXCHANGE?

"It takes an average of nine years for evidence to be put into practice." (Green, et al., 2009)

The Knowledge Exchange Centre is helping to reduce that time so as to improve the lives of Canadians living with a mental health problem or illness faster.

THE MENTAL HEALTH COMMISSION OF CANADA BELIEVES KNOWLEDGE CAN BE A CATALYST FOR ACTION, SO IT CREATED THE KNOWLEDGE EXCHANGE CENTRE TO PROMOTE THE DISSEMINATION AND IMPLEMENTATION OF RESEARCH ON MENTAL HEALTH.

The role of the Knowledge Exchange Centre (KEC) is to advance the vision and mission of the Mental Health Commission of Canada by fostering authentic engagement, respectful interaction and collaborative partnerships with key stakeholders.

The KEC has four main objectives:

1. To facilitate the development and mobilization of evidence-informed knowledge in the mental health community;
2. To increase the capacity of mental health stakeholders to routinely adopt and integrate knowledge exchange practices;
3. To explore potential pan-Canadian synergies and opportunities for collaboration;
4. To leverage existing best and promising practices across the country.

This past year was an extremely busy one for the KEC as it became fully staffed and fully functional.

* **Simon Davidson, MD, Chair, MHCC's Child and Youth Advisory Committee, speaks to delegates at the Canadian Psychiatric Association's Annual Conference where the MHCC held a symposium on Policy and Science Advances. Each year, more than 1,200 psychiatrists and other mental health care professionals attend the conference for the latest research, to exchange ideas, and to network with colleagues from across the country.**

SUPPORTING THE MHCC'S KNOWLEDGE EXCHANGE NEEDS

The KEC team works closely with the different initiatives and Advisory Committee projects of the MHCC, as well as other support teams, such as the Communication and Government Relations teams, to ensure that integrated dissemination plans are drafted and put into action.

For example, the KEC worked closely with the *Mental Health Strategy* team to begin longer-term planning around increasing the uptake and adoption of the *Strategy*. Among other things, it helped build an evaluation framework for assessing awareness and uptake of the *Strategy* and it provided some opportunities in Yukon and Newfoundland for the *Strategy* to be profiled during conferences and workshops.

During the course of the year, 16 of the 23 Advisory Committee projects transitioned to a knowledge exchange phase. The Mental Health and the Law Advisory Committee, for example, completed a study on the interaction between people with a mental illness and the police (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/MH_Law/MHCC_Police_Project3__ENG.pdf). The KEC and the authors of the report shared the results of the study at a Police Educators Curriculum Roundtable in Toronto, published an article in the RCMP Gazette (http://www.rcmp-grc.gc.ca/gazette/vol73n3/edge-avant-eng.htm), and presented at four conferences.

"You have been a catalyst in the development of the Canadian Primary Health Care Research Network (CPHCRN)... Since partnering with the Mental Health Commission of Canada, the CPHCRN has been able to grow and strengthen its ties with the mental health community."

William Hogg, MD, Professor and Senior Research Advisor, University of Ottawa, member of the Canadian Primary Health Care Research Network Executive Committee

In the fall, the Seniors Advisory Committee published the *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada* (http://www.mentalhealthcommission.ca/seniorsguidelines/). The KEC, in conjunction with the Seniors Advisory Committee, developed a pan-Canadian network to facilitate the uptake of the *Guidelines*, partnered with the Canadian Medical Association to feature them in their national database, and helped present them at several conferences.

The KEC also initiated three new flagship initiatives to address knowledge exchange capacity and reduce the time from innovation to implementation in two key areas:

1. **Collaborative Healthcare: Exchange, Evaluation, Research (CHEER project)**

   There is wide recognition in the mental health field that primary mental health care services and supports are inadequate throughout the country and need to be strengthened in order to prevent mental illnesses, intervene early at the onset of illnesses, and provide better outcomes for recovery.

   The KEC, in partnership with key stakeholders, is undertaking a pan-Canadian initiative called CHEER to contribute to measurable improvements in the field of primary mental health care and substance use in Canada.

   The members of the Steering Committee, who represent 11 national organizations, approved the following CHEER objectives:

   1. Improve access to quality primary mental health and substance use services in rural and remote communities;
   2. Increase the competencies of health care professionals to work collaboratively;
   3. Improve patient experience by fostering inter-professional collaboration and addressing barriers to accessing care;
   4. Advance the field of knowledge exchange by evaluating and publishing relevant outcomes related to the CHEER initiative.

   So far, the CHEER initiative has held consultations with 25 organizations across Canada, focusing on the themes of rural and remote communities, capacity/capability building, and technology.

   CHEER also received a $25,000 Meeting, Planning and Dissemination Grant from the Canadian Institutes of Health Research.

2. SPARK Training Institute

The MHCC created the SPARK Training Institute to improve the capacity for effective knowledge exchange for professionals engaged in the mental health, substance use and addictions systems.

At the beginning of 2012, a call for interest was sent across the country. SPARK received more than 70 applications to participate in a nine-month fellowship, starting with a two-day onsite workshop in July 2012 with internationally respected knowledge exchange professionals.

SPARK accepted 40 applications from eight different provinces and one territory. The applicants represented various fields in mental health: 19 practitioners, 10 researchers, five policy/decision makers, and six who were from a mix of those areas. After the training, the participants will receive ongoing mentoring for nine months in order to move from knowledge to action within their home organization.

3. Systems Performance Initiative

The KEC's Systems Performance Initiative is an effort to better understand the Canadian mental health landscape and to increase the decision maker's ability to make evidence-informed decisions.

This initiative has four key goals:

1. To promote the collection and use of available data and encourage new data collection from under-sampled populations;
2. To foster increased collaboration and data sharing among provinces and territories;
3. To aid in the development of a reporting mechanism that would provide a snapshot of the current state of mental health and mental illness in Canada;
4. To facilitate a network of key stakeholders that is focused on mental health and mental illness data collection.

At the onset of the next fiscal year, the initiative will seek approval for its work plan and begin its implementation.

MENTAL HEALTH AWARDS PROGRAM

The Mental Health Commission of Canada's 5th Anniversary National Mental Health Awards program will recognize innovative initiatives with a profound influence on the mental health system in Canada. These initiatives demonstrate the leadership, creativity and commitment of outstanding programs that advance our collective understanding of mental health and increase our ability to enhance the mental health of all Canadians. Launched on January 3, 2012 the MHCC 5th Anniversary National Awards Program, has received a total of 41 applications across seven jurisdictions.

NETWORK SUPPORT AND DEVELOPMENT

The KEC supports or has contributed to the development of a number of networks, including: the International Knowledge Exchange Network for Mental Health; the Ontario Mental Health and Addictions Knowledge Exchange Network; the Canadian Centre for Substance Abuse (CCSA) "Network of Networks"; the Coalition for Child and Youth Mental Health Ontario; the Collaborative Research Team Studying Bipolar Disorders; the Canadian Depression Intervention Network; and the Canadian Primary Health Care Research Innovation Network.

ADVANCING THE *MENTAL HEALTH STRATEGY FOR CANADA*

Changing Directions, Changing Lives: The Mental Health Strategy for Canada calls on all stakeholders to improve mental health data collection, research, and knowledge exchange in Canada. The KEC is putting these recommendations and more into practice. For example, the Collaborative Healthcare: Exchange, Evaluation, Research initiative (CHEER) addresses Strategic Direction #3 – to provide access to the right services, treatments and supports – while all of the SPARK Training Institute applications had to align with one or more of the *Strategy's* recommendations to be put into action.

MENTAL HEALTH FIRST AID

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MENTAL HEALTH FIRST AID

WHAT CAN A CUP OF COFFEE DO? IT CAN BE THE FIRST STEP IN HELPING SOMEONE YOU LOVE WHO MAY BE EXPERIENCING A MENTAL HEALTH PROBLEM OR ILLNESS. MENTAL HEALTH FIRST AID CANADA TRAINS PEOPLE TO RECOGNIZE THE SIGNS AND PROVIDE INITIAL HELP. AND THE FIRST MOVE IS OFTEN AS EASY AS HAVING A CONVERSATION.

WHY TRAIN CANADIANS?

It is critical to deal with physical emergencies quickly. It is just as important not to neglect a mental health emergency.

Mental Health First Aid Canada is an evidence based program of the Mental Health Commission of Canada that teaches people how to provide help to a person developing a mental health problem or experiencing a mental health crisis. The program aims to improve mental health literacy, reduce stigma and provide the skills and knowledge to help people better manage potential or developing mental health problems in themselves, a family member, a friend, or a colleague.

"[MHFA] is the best course I have ever taken. Anyone working in this type of job should have to take it, young or old. I would recommend this course for anyone that works or deals with mental health — personal or work-related."

Alberta Hospital (Health Care) employee

MENTAL HEALTH FIRST AID CANADA (MHFA) IS TRAINING THOUSANDS OF CANADIANS TO RECOGNIZE THE SIGNS OF A MENTAL HEALTH PROBLEM OR ILLNESS AND RESPOND TO EMERGING MENTAL HEALTH PROBLEMS OR EMERGENCIES.

Mount Royal University employees in Calgary receive training to become instructors in MHFA.

Lori-Anne Toone

A TRAINING MILESTONE

This year, Mental Health First Aid Canada trained more than 11,000 people across the country and surpassed a program milestone, training more than 50,000 Canadians to date.

Among those trained in 2011 – 2012 were families, teachers, health service providers, emergency workers, volunteers, human resources professionals, staff at community agencies, and municipal, provincial, territorial and federal employees. Courses were also taught in workplaces, at universities and colleges, and at correctional institutions.

INNOVATIONS TO EXPAND REACH

The continued interest in the program paved the way for innovations to begin. In order to better address the distinct mental health needs of Canadians, program adaptations for First Nations, Northern Peoples, and older adults in Canada began to take shape:

- A curriculum tailored for people residing in Canada's Northern Territories is underway and will be completed in 2013.
- Three First Nations communities have agreed to be involved in developing and testing the MHFA curriculum being created for First Nations across Canada.
- Negotiations with the Trillium Health Centre Foundation and the Credit Valley Hospital and Trillium Health Centre in Ontario began for a funded adaptation of MHFA for older adults in Canada. An editorial board consisting of leaders in geriatric mental health was established to review the curriculum content and provide guidance on the latest evidence in the mental health of older adults in Canada.

ADVANCING THE *MENTAL HEALTH STRATEGY FOR CANADA*

Changing Directions, Changing Lives: The Mental Health Strategy for Canada calls for an increase in the capacity of families, schools, workplaces, and those involved with seniors to intervene early when problems first emerge.

Mental Health First Aid works with people in all of these settings to improve public awareness of how to recognize mental health problems and illnesses and seek help.

Training in Mental Health First Aid is available across the country. In addition to the Basic Participant Course and the Adults Who Interact with Youth Course, Canadians can be trained to become instructors, so they can teach the program to others.

Visit the MHFA website (http://www.mental-healthfirstaid.ca/EN/Pages/default.aspx) and register.

PARTNERS FOR MENTAL HEALTH

PARTNERS FOR MENTAL HEALTH

NOW MORE THAN EVER, CANADIANS ARE TALKING ABOUT MENTAL HEALTH PROBLEMS AND MENTAL ILLNESSES. THESE CONVERSATIONS ARE RIPPLING THROUGH COMMUNITIES. BUT COULD THEY LEAD TO A WAVE OF CHANGE ACROSS THE COUNTRY? PARTNERS FOR MENTAL HEALTH IS ENGAGING ORDINARY CANADIANS TO MAKE THAT HAPPEN.

WHY A SOCIAL MOVEMENT?

Mental health is one of the last social taboos. One in five Canadians will experience a mental health problem or illness this year. Those affected by it risk waiting months to get help, being denied housing, being shunned at work, and being isolated from friends and family.

Partners for Mental Health is working to create a new state of mind in Canada regarding mental health that is free of shame and rich in support and understanding. To that end, Partners for Mental Health plans to introduce several national campaigns annually to enable Canadians to take action to support the mental health cause.

"It is great to see the level of engagement around the Not Myself Today campaign. Our hope is that this will serve as a catalyst to encourage Canadians to share their experiences about mental health. Together, we can transform and normalize a culture that is supportive and responsive to the needs of those living with mental health problems and illnesses ."

Rachel Bard, CEO, Canadian Nurses Association

PARTNERS FOR MENTAL HEALTH IS WORKING TO CATALYZE A SOCIAL MOVEMENT THAT WILL TRANSFORM THE WAY PEOPLE THINK ABOUT AND ACT TOWARD PEOPLE LIVING WITH A MENTAL HEALTH PROBLEM OR ILLNESS.

Rachel Bard, CEO, Canadian Nurses Association and Jeff Moat, President, Partners for Mental Health, sign the Not Myself Today pledge of support for mental health.

Greg Teckles

On April 2, 2012, the Partners for Mental Health (http://www.partnersformh.ca/) organization officially launched, with its inaugural campaign called Not Myself Today (http://www.notmyselftoday.ca/) aimed at engaging the general public in the mental health cause.

To get there, Partners for Mental Health spent a great deal of the year building the organization from the ground up. It became fully staffed, hiring professionals in the areas of marketing, volunteering and online community engagement. Several key agencies were brought onboard to work on the development of plans, campaigns and activities. As a result, an overall strategic plan was created, along with a detailed go-to-market plan based on extensive input and consultation with key stakeholders, and the Partners for Mental Health brand and visual identity were unveiled.

Partners for Mental Health is about public engagement, so it created a dynamic, engaging website with online donation functionality as well as a robust back-end relationship management system.

It also built a solid volunteer base, recruiting more than 100 volunteers and forming 18 Community Action Teams across the country to spread the word and get Canadians mobilized for the cause.

Finally, a comprehensive plan was created for the Not Myself Today campaign, including the creative direction and key messages, advertising and media buys, direct marketing, public relations, volunteer plans and more.

People in downtown Toronto check out the mood wall installation featuring multi-coloured mood pins as part of the campaign's Day of Action.

All of this work culminated in the official launch of the Partners for Mental Health organization in April. By the end of the six-week campaign, more than 80 key stakeholders and organizations across Canada had committed their support to the mental health cause, almost 200 schools and workplaces had signed up to host a Day of Action, more than 27,000 Canadians had taken an online pledge to support mental health, and more than 700 personal stories were submitted.

Additionally, several private sector financial sponsors were secured, including two Major Sponsors – Lundbeck Canada Inc. and Scotiabank – three Supporting Sponsors, and two Events and Campaign Sponsors.

ADVANCING THE *MENTAL HEALTH STRATEGY FOR CANADA*

Changing Directions, Changing Lives: The Mental Health Strategy for Canada calls on all Canadians to promote mental health in everyday settings and reduce stigma. It also requires the sustained efforts and active engagement of key stakeholder organizations and members of the general public across Canada.

Partners for Mental Health will empower individuals and organizations across the country to take actions that support the recommendations contained within the *Strategy,* leading to unprecedented improvements in mental health services, mental health project funding and the mental well-being of all Canadians. These actions will include paying more attention to one's own mental well-being, supporting others and becoming involved with the cause through volunteering, influencing policy and/or fundraising activities.

Partners for Mental Health began as an initiative of the Mental Health Commission of Canada, but on April 1, 2012, it became a national charitable organization independent of the MHCC.

ADVISORY COMMITTEES

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ADVISORY COMMITTEES

* THERE ARE MANY AREAS IN NEED OF IMPROVEMENT IN CANADA'S MENTAL HEALTH SYSTEM . THE MHCC IS SUPPORTED BY EIGHT ADVISORY COMMITTEES THAT ARE TAKING A CLOSER LOOK AT SOME OF THE MOST IMPORTANT AREAS.

THE COMMITTEES ARE COMPRISED OF MORE THAN 100 EXPERTS, ACADEMICS, PEOPLE WITH LIVED EXPERIENCE OF A MENTAL HEALTH PROBLEM OR ILLNESS, AND FAMILY CAREGIVERS.

TOGETHER THEY HAVE BEEN ENGAGED IN MORE THAN TWO DOZEN PROJECTS ACROSS THE COUNTRY THAT HELPED INFORM THE DEVELOPMENT OF THE MENTAL HEALTH STRATEGY FOR CANADA.

WHY CHILDREN AND YOUTH?

Mental health problems and illnesses most frequently have their onset in childhood, yet children's mental health needs are neither well understood nor well served.

The Child and Youth Advisory Committee is guiding projects to advance children's mental well-being and to support early identification and intervention of emerging mental health concerns as early in a child's life as possible. These actions are focused on optimizing their life trajectories, their productivity as Canadians and reducing the impact of mental health problems in adulthood.

THE CHILD AND YOUTH ADVISORY COMMITTEE IS PURSUING THE BEST EVIDENCE TO INFORM, SUPPORT AND ENCOURAGE COLLABORATIVE ACTION TO DEAL WITH THE MENTAL HEALTH NEEDS OF YOUNG CANADIANS.

GUIDING POLICY AND PROGRAMS

The Evergreen Framework (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/family/Evergreen_Framework_English_July2010_final.pdf), an evidence-based guide for child and youth mental health policy and program development, is seen as a critical foundation to guide all of the Commission's work related to children's mental health.

The Framework was used this school year in a pilot project of the Ontario Shores Centre for Mental Health Sciences.

Ontario Shores partnered with Stan Kutcher, MD, the Sun Life Chair in Adolescent Mental Health (who also led the development of the Evergreen Framework), to apply an evidence-based school mental health curriculum for grades 9 and 10 and include educator and primary health care provider mental health training.

The curriculum and teacher training were developed to improve mental health literacy (including stigma reduction) for both teachers and students. The other training programs were developed to better equip educators and health practitioners to identify, triage, diagnose, treat and support youth with mental disorders.

Jessica Bruhn, Co-chair of the BC Provincial Family Council, speaks at the Child and Youth Mental Health Matters Conference in Vancouver. The event was co-hosted by Keli Anderson, a member of the MHCC's Child and Youth Advisory Committee.

Andriy Mishchenko

Kutcher took part in the training of more than 250 primary care providers, teachers, educators and allied support staff, and the curriculum is being evaluated as it is being applied in 18 schools across four school boards in Ontario. It is estimated that more than 100 secondary schools in Ontario and elsewhere in Canada will be using the mental health curriculum, with numerous other training sessions being provided to more than 150 more schools in the next school year.

DETERMINING NEED IN SCHOOLS

In 2011-2012, the Child and Youth Advisory Committee supported the School-Based Mental Health and Substance Abuse Project (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/SBMHSA/SBMHSA_Summary_ENG.pdf), a comprehensive research project determining the current state of mental health and substance use programs and practices in Canadian schools.

A group of 40 leading researchers, policy makers and practitioners reviewed (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/SBMHSA/SBMHSA_Review_ENG.pdf) literature from all over the world on mental health and substance use, conducted a scan (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/SBMHSA/SBMHSA_Scan_ENG.pdf) of best practices in Canadian schools, and surveyed (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/SBMHSA/SBMHSA_Survey_ENG.pdf) school boards and schools seeking input on the state of child and youth mental health programs.

Over 80% of survey respondents from 177 school districts indicated there were unmet student mental health needs in schools. Recommendations from this project included increasing investment in mental health promotion/social emotional learning initiatives, adding more trained mental health professionals in schools and developing systematic professional learning in mental health for educators.

ENGAGING YOUTH AND PREVENTING STIGMA

The Committee's youth knowledge mobilization project included a literature review of popular youth websites, which sought information on which health-oriented sites are popular and how social media is used in health promotion.

In addition, data was collected from nearly 300 youth between the ages of 12 to 18 on their perceptions of mental health, who they turn to for help, what language is perceived as most useful in reducing stigma, and their experiences with social media.

The project also involved online surveys and interviews with youth asking them what they want to know about mental health.

The MHCC is planning to release the results of this project in the coming fiscal year, providing an initial research-based foundation for the creation and implementation of mental health knowledge in ways that are youth-centric.

PROVIDING SUPPORT TO PARENTS

The Committee guided a literature review and environmental scan that will inform the development of a family-centred framework on parental mental health education and support for parents of adolescents. This framework will assist with the development of programs that help parents to become more aware about the early signs of mental health problems in children and youth.

TRANSITION FROM YOUTH TO ADULTHOOD

A new project was launched to provide guidance on policy and practice options to improve the processes of youth transitioning to adult mental health services, in order to improve outcomes and sustain continuity and engagement in programs and services. Data will be collected nationally and internationally, with the project continuing into 2013. The Committee also began seeking potential partners and external funding to implement the recommendations.

The MHCC's Youth Council acquired four new members in 2011–2012. The Council, comprised of young Canadians who have experience living with a mental health problem or illness, provides feedback on MHCC programs and projects from the youth perspective. Its members may also sit on other Committees or engage in specific projects and initiatives.

Watch (http://www.youtube.com/watch?v=6wV_oNLUNdc) an animated film created by Simran Lehal, a member of the Youth Council, capturing "a personal definition of mental health". The film was awarded top honours in the Living Life Fully Film Festival contest, a community festival in Prince George, BC.

WHY FAMILY CAREGIVERS?

There are often hardships associated with long-term caregiving that can affect the caregiver's own well-being. To be able to fulfill their responsibilities and at the same time sustain their own well-being, caregivers require information, education, guidance and support.

The Family Caregivers Advisory Committee is working towards a mental health system that will promote full and meaningful lives for people living with mental health problems and illnesses, and for their families and friends who often serve as their primary support network. The Committee aims to ensure that the support they require to fulfill their caregiving responsibilities is available in all communities.

THE FAMILY CAREGIVERS ADVISORY COMMITTEE IS HELPING TO CREATE TOOLS TO HELP SUSTAIN THE MENTAL HEALTH AND WELL-BEING OF CAREGIVERS WHILE THEY CARE FOR THEIR LOVED ONES.

MEETING THE NEEDS OF CAREGIVERS

The Committee continued work on an unprecedented document expected to benefit caregivers across the country. Initiated by the Committee and overseen by a multi-disciplinary steering committee, the *National Guidelines for a Comprehensive Service System For Family Caregivers of Adults With Mental Health Problems and Illnesses* will target policy makers and service providers.

The Committee presented the *Guidelines* framework to focus groups in six locations across Canada. More than 80 participants volunteered their expertise and shared their feedback. The participants represented diverse linguistic, ethno-cultural and socio-economic backgrounds and included caregivers, people with lived experience, and service providers with a variety of perspectives and positions within the mental health system.

The *Guidelines* are expected to be released in 2013 and will encourage the review of existing family caregiver services and supports and the enhancement and development of new ones. They will include recommendations for service providers and policy makers on the types of services and supports that family caregivers find most helpful as well as the inclusion of people living with mental illnesses, and their families, in the planning of support services.

WHY FIRST NATIONS, INUIT AND MÉTIS?

There is a realization that there will be many challenges in overcoming historical issues that have destroyed the substance of family and community, and have contributed to mental health problems in the First Nations, Inuit and Métis communities.

The First Nations, Inuit and Métis Advisory Committee is working to promote overall mental health and reduce the threats to well-being among Indigenous people living in communities on and off reserves in Canada.

THE FIRST NATIONS, INUIT AND MÉTIS ADVISORY COMMITTEE IS WORKING TO INCREASE KNOWLEDGE AND UNDERSTANDING WITH RESPECT TO ISSUES OF CULTURAL SAFETY, SOCIAL JUSTICE, ETHICAL ACCOUNTABILITY AND DIVERSITY COMPETENCY.

SPREADING THE WORD ABOUT CULTURAL SAFETY

The Committee worked with the MHCC's Knowledge Exchange Centre in this fiscal year to disseminate the findings of the cultural safety project.

This project demonstrates how the application of cultural safety as a value, principle, and practice assists individuals, families, and communities of diverse cultures to experience more positive outcomes when accessing mental health resources and services. A presentation of the curriculum was showcased at two events in the fall, and new partnership opportunities continue to be explored.

UNDERSTANDING TECHNOLOGY TO PROMOTE WELLNESS

In October 2011, the MHCC approved the First Nations, Inuit and Métis Child, Youth and Family Mental Wellness Project for scoping.

The main objective of this project is to better understand the potentially significant role of technology in promoting mental wellness in urban, rural and remote areas.

The project will identify promising practices for using new and emerging technologies such as social media, photo voice, digital storytelling, mobile applications and the Internet, to enhance the mental wellness of First Nations, Inuit and Métis peoples through the promotion of culture, identity and connectedness.

The project is the result of a collaborative and shared vision by the MHCC's Child and Youth Advisory Committee, First Nations, Inuit, and Métis Advisory Committee, Service Systems Advisory Committee, Mental Health and the Law Advisory Committee, and the Family Caregivers Advisory Committee.

All work on this scoping project must be completed in 2013. Deliverables will include a literature review, an environmental scan and an assessment on how feasible it is to implement the initiatives in a selected number of rural and remote communities throughout Canada.

WHY MENTAL HEALTH AND THE LAW?

People with mental health problems and illnesses may face unique challenges concerning their legal and human rights particularly when interacting with police, the justice system and other correctional authorities, but also when seeking health care services.

The Mental Health and the Law Advisory Committee is examining how well the justice system is equipped to interact with, and meet the needs of, Canadians living with mental health problems and illnesses. The Committee is also assessing how legislation impacts the human rights of those people.

THE MENTAL HEALTH AND THE LAW ADVISORY COMMITTEE IS RECOMMENDING CHANGES TO LEGISLATION, POLICIES AND SERVICES TO ENSURE THAT PEOPLE WITH MENTAL HEALTH PROBLEMS AND ILLNESSES RECEIVE PROPER CARE IN THE JUSTICE SYSTEM. THE RECOMMENDATIONS ARE INTENDED TO ENSURE THEY ARE NOT DISCRIMINATED AGAINST ON THE BASIS OF THEIR MENTAL HEALTH STATUS AND ARE TREATED WITH THE LEAST RESTRICTIVE OPTIONS THAT RESPECT THEIR CAPACITY FOR SELF-CARE.

* **Participants from police colleges and police services join curriculum developers and people with lived experience to discuss recent research findings on training and education about mental illness for police officers. The Police Educators Curriculum Roundtable was hosted by the MHCC in Toronto and coincided with the release of *A Study of How People with Mental Illness Perceive and Interact with the Police.***

Paul Wright

IMPROVING OUTCOMES OF POLICE INTERACTIONS

The Committee guided a study on Canadians' experiences with, and attitudes toward, the police. *A Study of How People with Mental Illness Perceive and Interact with the Police* (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/MH_Law/MHCC_Police_Project3_ENG.pdf) involved more than 200 people in British Columbia. It was the first in Canada to examine the perceptions and experiences of people with a mental illness related to their police interactions.

The results suggested that many people with lived experience have positive interactions with police services. They also suggest a need for specialized training and other strategies to support police personnel in situations involving people with a mental illness.

> *"[A Study of How People with Mental Illness Perceive and Interact with the Police]* is a timely examination of the frequency of interaction between police and those suffering from mental illness...We applaud your efforts to transform health, mental illness, and addiction services in Canada."
>
> Andrea Risk, Chair of the Kingston Police Services Board, Kingston, Ontario

Participants commented that police officers should be encouraged to adopt a more compassionate, empathetic and respectful approach in their interactions with people who have mental health problems and illnesses.

Results of the study were presented in Canada and internationally, including at the International Association of Chiefs of Police Conference in Chicago, the International Association of Forensic Mental Health Services Conference in Spain, and the Annual Pacific Forensic Psychiatry Conference in Vancouver.

A model for police education developed by the Committee, known as Training and Education about Mental Illness for Police Officers (TEMPO), was also presented here and abroad at conferences including the Annual Pacific Psychiatry Conference, the International Association of Chiefs of Police Conference, and the annual convention of the Canadian Psychological Association.

The Committee also continued its work facilitating cooperation among police agencies and mental health service providers.

EVALUATING CANADA'S MENTAL HEALTH LEGISLATION

Changing Directions, Changing Lives: The Mental Health Strategy for Canada states Canada's ratification of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) provides a new touchstone for legislation, policies and regulations.

Recognizing the implications of Canada's ratification and the human rights of people living with a mental health problem or illness, the Committee collaborated with the Canadian Mental Health Association – Winnipeg Region, and the Public Interest Law Centre of Legal Aid Manitoba, to develop an instrument for evaluating the alignment of human rights within Canadian mental health legislation, policies and services with the CRPD. A report on the project will be released in 2012 and partners interested in piloting the instrument are currently being sought.

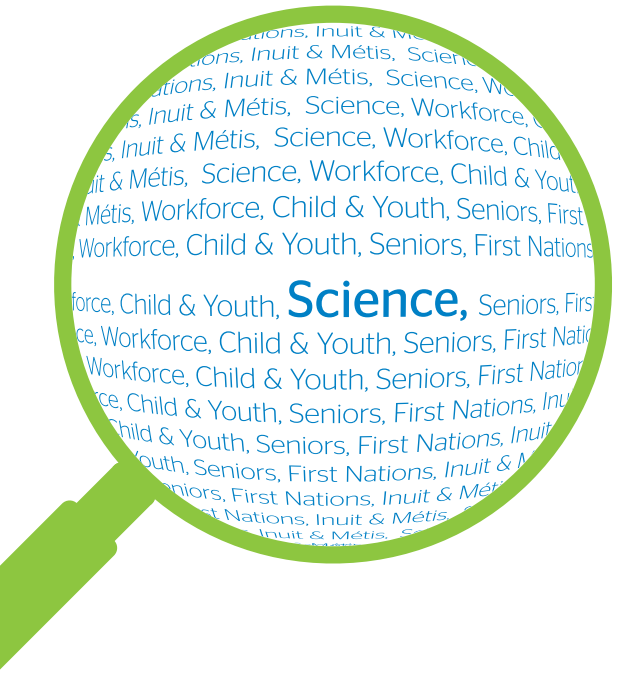
EXAMINING SYSTEM TRAJECTORIES

The Committee continued to examine the paths, or "trajectories", through the health and justice system of individuals declared not criminally responsible on account of mental disorder (NCRMD) who are under the authority of a provincial or territorial Review Board. The goal of this project is to inform clinical, organizational, and legislative changes related to these individuals and to learn how the system is perceived and experienced by persons found NCRMD, their families, legal professionals and mental health professionals across Canada.

Data collection in Québec, British Columbia and Ontario, where the majority of these cases in Canada occur, continued this year. The project will be completed in 2013.

MONITORING POTENTIAL DISCRIMINATION

Some police services currently make information related to a person's mental health available during checks of police records. The Mental Health and the Law Advisory Committee released a statement (http://goo.gl/y593N) describing this practice as discriminatory and stigmatizing. The Committee is calling for a national policy on this issue to be developed.



WHY SCIENCE?

Mental health is a complex issue that requires all perspectives to be considered.

The Science Advisory Committee ensures that scientific evidence and research-based knowledge is taken into consideration and included across the work of the MHCC where possible. Comprised of some of Canada's leading scientific and mental health experts, the Committee strengthens and incorporates the perspective and understanding of the causes of mental health problems and illnesses with consideration for the effects of medications, treatments, and interventions.

THE SCIENCE ADVISORY COMMITTEE IS PROVIDING STRATEGIC COUNSEL AND GUIDANCE ON MANY MHCC PROJECTS.

IMPROVING SERVICES FOR DIVERSE COMMUNITIES

The Committee and other partners created the Multicultural Mental Health Resource Centre. This web-based initiative provides resources aimed at improving the quality and availability of mental health services for people from diverse cultural and ethnic backgrounds, including immigrants, refugees, and members of established ethno-cultural communities.

The Centre's website underwent a major overhaul in 2011. Many new resources were added, the site was redesigned to become more user-friendly, and the coding was overhauled for better performance and future expansion.

With support from the MHCC, the Centre is developing three new resources to serve the multicultural mental health community. The development of the first resource, a training tool for health care providers, began in 2011 and all three resources are expected to be completed by 2014.

UNDERSTANDING DATA AND HOW IT IS GATHERED

Access to and utilization of high quality data are cornerstones of effective decision making that can help improve the lives of people living with a mental illness and this is an area of opportunity in the Canadian mental health landscape.

The Science Advisory Committee, the Service Systems Advisory Committee, and the Knowledge Exchange Centre are coordinating a national project around data which will inform the MHCC's systems performance initiative.

This project is determining how to better understand existing data and data collection mechanisms. For example, how many people seek mental health services each year versus those who are able to receive services.

Caregivers, people with lived experience, decision makers, researchers and front line practitioners are partners in this project.

WHY SENIORS?

Mental health problems and illnesses are not a normal consequence of aging. Treatments and supports are available for older adults to experience recovery and well-being. All seniors have the right to receive the services and care necessary to meet their mental health needs.

The Seniors Advisory Committee ensures that the mental health of older adults in Canada is taken into consideration and included across the work of the MHCC where possible.

THE SENIORS ADVISORY COMMITTEE IS IMPROVING MENTAL HEALTH SERVICES FOR OLDER ADULTS IN CANADA BY CREATING AND DISSEMINATING BEST PRACTICES, ENCOURAGING ADOPTION AND ADAPTATION, AND RECOMMENDING POLICY AND SERVICE CHANGES INFORMED BY UP-TO-DATE EVIDENCE.

GUIDELINES FOR BETTER CARE

The *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada* (http://www.mentalhealthcommission.ca/English/Pages/MHCC_Seniors_Guidelines.aspx) were launched in October 2011 at the Canadian Academy of Geriatric Psychiatry meeting in Vancouver. An interactive version of the document was also created and includes more than 100 links to additional resources. The *Guidelines* continue to be shared throughout the country with the intention to influence policy and encourage service improvements for mental health services for older adults in Canada.

The MHCC, through the Seniors Advisory Committee, formally partnered with the Canadian Coalition for Seniors' Mental Health and the Canadian Dementia Resource and Knowledge Exchange to foster the sharing and dissemination of the *Guidelines* as well as to promote the exchange of information around seniors' mental health in Canada.

AN ANTI-STIGMA TOOL

Seniors living with a mental illness can face a double-dose of stigma—the stigma of aging as well as the stigma of mental illness. Evidence shows that seniors identify stigma from health professionals as a barrier to seeking help and adhering to treatment and support programs. As a result, the Seniors Advisory Committee designed a conceptual framework for addressing stigma experienced by seniors based on the approaches used by the MHCC's Opening Minds initiative. The tool is being developed specifically for health care professionals and is expected to be available in 2013.

Co-authors (L to R) Kimberly Wilson, Marie-France Tourigny-Rivard, MD and Penny MacCourt, PhD, launch the *Comprehensive Guidelines for Older Adults in Canada* in Vancouver.

Andriy Mishchenko

WHY SERVICE SYSTEMS?

Mental health care is comprised of a range of factors such as social networks, education, housing and more. Each of these must work well in order to meet the needs of people living with mental health problems and illnesses, and their families.

The Service Systems Advisory Committee provides advice on the ingredients necessary to ensure that mental health systems are able to best meet the needs of people living with a mental illness.

THE SERVICE SYSTEMS ADVISORY COMMITTEE IS INFORMING THE CREATION OF A HIGH PERFORMING MENTAL HEALTH SYSTEM BY DEVELOPING A STRATEGY ON HOUSING AND SUPPORTS, STUDYING BEST PRACTICES IN PEER SUPPORT, AND EXAMINING STRATEGIES TO MEET THE NEEDS OF AN INCREASINGLY ETHNICALLY DIVERSE POPULATION.

Members of the MHCC's Service Systems Advisory Committee.

Back row (L to R): Pierre Beauséjour, MD, John Higenbottam, PhD, Albert Hajes, Paul Hanki, Reid Burke, Ken Ross and Kwame McKenzie, MD

Front row (L to R): Vicky Huehn, Francine Lemire, MD, Frankie O'Neill , Steve Lurie (Chair), Ted Lo, MD, Judy Watson and Sri Pendakur

A CALL TO INCREASE HOUSING SUPPLY

In 2011-2012, the Committee informed the Commission on the housing and community support needs of Canadians living with mental health problems and illnesses with the release of the *Turning the Key* (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/AtHome-ChezSoi/TurningTheKey_Full_ENG_NEW.pdf) report.

The report recommended 100,000 supportive housing units be developed and funded over the course of the next 10 years in Canada.

> "Having facilitated a number of the meetings of the national leadership peer support network, I can personally attest to the passion, commitment, doggedness, effort, determination, energy fervency, and, dare I say it, love that these people bring to the work."
>
> Karen Liberman, Former Executive Director of the Mood Disorders Association of Ontario, and now a mental health advisor

Other recommendations included:

- The MHCC should develop plans to ensure that participants in the At Home/Chez Soi project continue to access housing and recovery-oriented support when the research phase of the project expires.
- The federal government should continue to collaborate with provincial and territorial governments to address affordable mental health housing with supports.
- The MHCC should work with federal, provincial, and territorial governments to ensure that current and future mental health strategies developed in partnership with First Nations, Inuit, and Métis include actions to improve the supply and quality of housing and supports.

The report was released at the Canadian Mental Health Association—Toronto annual general meeting.

REACHING OUT TO DIVERSE POPULATIONS

The Service Systems Advisory Committee continued reaching out to Canada's cultural and ethnically diverse groups, disseminating the MHCC's 2009 report titled *Improving Mental Health Services for Immigrant, Refugee Ethno-cultural and Racialized Groups: Issues and Options for Service Improvement* (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2010/issuesandslides.pdf). The report, which aims to promote promising practices related to health promotion and service improvement, will be available on the MHCC website in Cantonese and Punjabi in the next fiscal year. It is currently available in English and French.

ENHANCING THE USE OF PEER SUPPORT

Peer support works because people who have experience with mental health problems and illnesses can offer support, encouragement and hope to each other when facing similar situations. Peer support can be offered wherever people need it — at peer-run organizations, workplaces, schools or healthcare settings.

It is recognized that there are variations to providing valuable and effective peer support in Canada and a "one size fits all" approach does not work.

Building on the Service Systems Advisory Committee's 2010 report, *Making the Case for Peer Support* (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Peer%20Support/Service%20Systems%20AC%20-%20Peer%20support%20report%20EN.pdf), the Commission

* **The Peer Support Leadership Team meets in Toronto in early 2012 to provide advice and guidance to the MHCC's Peer Project.**

Top row (L to R): Ella Amir, PhD, Chris Summerville, Diana Capponi, Eugene Leblanc, Karon-Ann Parsons, Frances Skerritt, Roy Muise, Donna Hardaker and Brian Eaton

Bottom row (L to R): LCol Stéphane Grenier, Sandy Palinski, Rachel Thibeault, PhD, Karen Liberman, Patrick Raymond, Debbie Sesula, Debbie Wiebe and Kim Sunderland

launched the Peer Project, with the goal of enhancing the use of peer support through the creation of national guidelines of practice. This project is being led by peer support workers from across Canada.

The project conducted cross-country consultations and a Peer Leadership Group consisting of regional peer support leaders from most provinces and territories across Canada was formed. The group offers advice and guidance and has been pivotal in moving the project forward and assisting with understanding the landscape and needs of peer support in Canada.

BUILDING AWARENESS OF PEER SUPPORT

The MHCC's Peer Project hosted a series of meetings in Ottawa during Mental Illness Awareness Week to garner support and build awareness of peer support in the workplace. The meetings included stakeholders from various sectors including business, government, law enforcement, education, health care and social services.

A special event included speeches from the President and CEO of the MHCC, Louise Bradley; Peer Project Team Leader Stéphane Grenier; the Honourable Michael Kirby, Chair of the MHCC; and Karen Liberman, the former Executive Director of the Mood Disorders Association of Ontario who spoke of her personal experience with mental illness.

A related event was held to launch the *Alberta Lieutenant Governor's Circle on Mental Health and Addiction*. The event was attended by His Honour, Col. (Ret'd) the Honourable Donald S. Ethell, the Lieutenant Governor of Alberta, and Senator Roméo Dallaire, a renowned advocate of peer support.

Watch video of presentations at an MHCC peer support meeting in Ottawa, on October 5, 2011 via the links below:

Stéphane Grenier (http://www.youtube.com/watch%3Fv%3Dqec6FnBd528%26feature%-3Drelmfu), the MHCC's Peer Support Project Team Leader, speaks about the importance of keeping peer support simple and the necessity to preserve its grass-roots authenticity, regardless of the setting in which peer support takes place.

Senator Roméo Dallaire (http://www.youtube.com/watch%3Fv%3D6REW4QQWoxg), an advocate of peer support, emphasizes that families need to be part of the solution in addressing mental health problems and illnesses, and said the solution is fundamentally based on peer support.

Peer support advocate Karen Liberman (http://www.youtube.com/watch%3Fv%3D-letJoWkvi64%26feature%3Dplcp), the former Executive Director of the Mood Disorders Association of Ontario, reminds everyone why peer support workers are so dedicated to the work that they do.

The Chair of the MHCC, the Honourable Michael Kirby (http://www.youtube.com/watch%3Fv%3Db-f0NsTXkik%26feature%-3Drelmfu), speaks to the importance of peer support.

THE WORKFORCE ADVISORY COMMITTEE IS HELPING EMPLOYERS CHANGE AND IMPROVE HOW THEY PROTECT EMPLOYEE MENTAL HEALTH IN THEIR WORKPLACES TO BETTER PREVENT MENTAL HEALTH PROBLEMS AND ILLNESSES.

The MHCC's President and CEO Louise Bradley discusses developments toward the creation of the *National Standard of Canada for Psychological Health and Safety in the Workplace* at an event in Ottawa. The *Standard* will be released in 2012.

Cynthia Münster

WHY THE WORKFORCE?

Mental health problems and illnesses are the leading cause of short- and long-term disability in Canadian workplaces, and the financial and personal impacts are substantial.

The Workforce Advisory Committee is developing tools to improve the mental health of employees with a focus on prevention. It is also focusing on the barriers that must be dismantled as they pertain to job re-entry, finding employment, sustainable income and skill development.

HELPING EMPLOYERS TAKE ACTION

The Committee launched a tool this year to help employers who are considering policies to improve psychological health in their organizations.

Psychological Health and Safety: An Action Guide for Employers, (http://www.mentalhealth-commission.ca/SiteCollectionDocuments/Workforce/Workforce_Employers_Guide_ENG.pdf), which is available to employers at no cost, provides a series of steps and 24 actions accessible to all Canadian employers regardless of size, sector or location.

It was created for Canadian organizations that recognize the value in addressing the psychological health of their workplace and workers, but have been unclear or unsure where to start.

It will also help employers prepare to implement the upcoming *National Standard of Canada for Psychological Health and Safety in the Workplace*.

The *Guide* was developed by Merv Gilbert, PhD, and Dan Bilsker, PhD, with the Centre for Applied Research in Mental Health and Addiction at Simon Fraser University.

VOLUNTARY STANDARD PROGRESSING

The Committee and its partners made significant progress in their work to create the *National Standard of Canada for Psychological Health and Safety in the Workplace*. A draft was released for public review in November 2011, with feedback being incorporated into a final draft.

The voluntary *Standard,* expected to be launched by the end of 2012, is intended to provide guidelines for Canadian employers to enable them to develop and continuously improve psychologically safe and healthy work environments.

The ultimate goal is to take a complex subject and make it easier for employers to take steps to prevent mental injury, reduce psychological risk and promote a mentally healthier workplace.

It is anticipated that the *Standard* will align with existing relevant standards or those currently under development.

MAKING THE LEGAL CASE FOR IMPROVEMENT

The Committee released the final in a series of three reports examining a potential legal storm for employers who fail to maintain a psychologically safe workplace.

The reports were prepared by Martin Shain, PhD, at the University of Toronto. The most recent report, *The Road to Psychological Safety: Legal, Scientific and Social Foundations for a National Standard for Psychological Safety in the Workplace* (http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Workforce_2011/The_Road_to_Psychological_Safety.pdf), looked at the risks of mental injury at work and how the development of a national safety standard could protect mental health.

SUPPORTING THE "ASPIRING WORKFORCE"

A disproportionate number of people in Canada with serious mental illness are unemployed and the number of people with mental illness transitioning onto disability income support programs is rising.

An MHCC project has been studying the causes of what is holding back this "aspiring workforce" and will be recommending potential solutions. In the past year, the Committee submitted a report to the MHCC that includes a review of supported employment in Canada, an overview of provincial disability programs and work incentives, as well as an environmental scan of businesses that have been developed to address employment and economic disadvantages experienced by people with mental illnesses.

The report is being reviewed prior to release in the next fiscal year.

LEADERSHIP AND GOVERNANCE

BOARD OF DIRECTORS

Lorraine Janet Breault, PhD
University of Alberta
Alberta

François Borgeat, MD
Hôpital Louis-H. Lafontaine
Québec

Patrick Dion
Government of Ontario
Ontario

Madeleine Dion Stout
Dion Stout Reflections Inc.
British Columbia

Dan Florizone
Government of Saskatchewan
Saskatchewan

David Goldbloom, MD (Vice Chair)
Centre for Addiction and Mental Health
Ontario

Dana Heide
Government of the Northwest Territories
Northwest Territories

Mark Henick
Nova Scotia

Michael Kirby (Chair)
Ontario

Jeannette Leblanc
New Brunswick

Kevin McNamara
Government of Nova Scotia
Nova Scotia

James A. Morrisey
Ontario

Peter Ralph
Simmonds and Partners Defence
Newfoundland and Labrador

Fern Nancy Stockdale Winder, PhD (Vice Chair)
Saskatoon Health Region
Saskatchewan

Chris Summerville
Schizophrenia Society of Canada
Manitoba

Milton Sussman
Government of Manitoba
Manitoba

Manitok Thompson
Nunavut

Glenda Yeates
Health Canada
Ontario

Please note: Some directors did not serve for the full fiscal year.

EXECUTIVE LEADERSHIP TEAM

Jayne Barker, PhD
Vice President, Mental Health and Homelessness, and Policy and Research

Louise Bradley
President and CEO

Geoff Couldrey
Executive Vice President

Cameron Keller
Vice President, Mental Health and Homelessness

Michelle McLean
Vice President, Public Affairs

Jeff Moat
Vice President, Partners for Mental Health

Nathalie Pichette
Chief Financial Officer

Lawrence Green
Chief Financial Officer

Please note: Some executives did not serve for the full fiscal year.

ADVISORY COMMITTEE CHAIRS

CHILD AND YOUTH
Simon Davidson, MD
Children's Hospital of Eastern Ontario

Nancy Reynolds
Alberta Centre for Child, Family and Community Research

FAMILY CAREGIVERS
Ella Amir, PhD
AMI-Québec

FIRST NATIONS, INUIT AND MÉTIS
Mike DeGagné

MENTAL HEALTH AND THE LAW
Patrick Baillie, PhD
Alberta Health Services and Calgary Police Service

Edward F. Ormston
Ontario Court of Justice

SCIENCE
Elliot Goldner, MD
Simon Fraser University

SENIORS
Marie-France Tourigny-Rivard, MD
University of Ottawa

SERVICE SYSTEMS
Steve Lurie
Canadian Mental Health Association, Metro Toronto Branch

WORKFORCE
Ian Arnold, MD
Health, safety and environmental management consultant

Charles J. Bruce
Nova Scotia Public Service Long Term Disability Plan Trust Fund

Please note: Some Advisory Committee chairs did not serve for the full fiscal year.

FINANCIAL STATEMENTS OF MENTAL HEALTH COMMISSION OF CANADA

Year ended March 31, 2012

INDEPENDENT AUDITORS' REPORT TO THE MEMBERS

We have audited the accompanying financial statements of Mental Health Commission of Canada which comprise the statement of financial position as at March 31, 2012, the statements of operations and changes in net assets and cash flows for the year then ended, and notes, comprising a summary of significant accounting policies and other explanatory information.

MANAGEMENT'S RESPONSIBILITY FOR THE FINANCIAL STATEMENTS

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian generally accepted accounting principles, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

AUDITORS' RESPONSIBILITY

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 comply with ethical requirements and plan and perform an audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

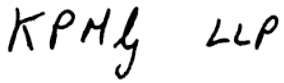
An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

OPINION

In our opinion, these financial statements present fairly, in all material respects, the financial position of Mental Health Commission of Canada as at March 31, 2012, and its results of operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Chartered Accountants



June 12, 2012

Calgary, Canada

STATEMENT OF FINANCIAL POSITION

March 31, 2012, with comparative figures for 2011

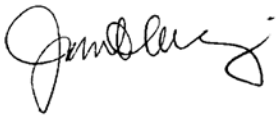
	2012	2011
ASSETS		
Current assets		
Cash and cash equivalents	$ 13,353,895	$ 4,480,515
Short term deposits	7,964,495	2,204,822
Contract advances	402,018	2,881,345
Accounts receivable	456,244	654,120
GST receivable	816,482	377,595
Deposits and prepaid expenses	109,628	149,526
Inventory	55,373	52,985
Investments (note 3)	17,654,091	43,463,346
	40,812,226	54,264,254
Long term investments (note 3)	-	18,884,861
Capital assets (note 4)	1,606,477	1,711,705
	$ 42,418,703	$ 74,860,820

	2012	2011
LIABILITIES AND NET ASSETS		
Current liabilities		
Accounts payable and accrued liabilities	$ 5,172,089	$ 6,967,591
Deferred program fees	33,075	28,024
Deferred contributions – operating (note 5)	34,616,890	36,558,756
	39,822,054	43,554,371
Deferred capital contributions (note 6)	1,606,477	1,711,705
Deferred contributions – operating (note 5)	-	29,479,012
Net assets	990,172	115,732
Commitments (note 7)		
	$ 42,418,703	$ 74,860,820

See accompanying notes to financial statements

On behalf of the Board:

Director, Patrick Dion



Director, James Morrissey

STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS

Year ended March 31, 2012, with comparative figures for 2011

	2012	2011
Revenues:		
Grant income (note 5)	$ 47,582,964	$ 42,755,781
Mental health first aid income	1,132,273	792,855
Interest and other income	145,854	67,465
	48,861,091	43,616,101
Expenses:		
Direct client services (note 9)	26,556,596	24,575,370
Salaries and benefits	9,241,157	7,967,485
Services	7,164,133	6,193,042
Travel	2,168,147	2,411,421
Rent	908,913	673,791
Meetings and events	615,360	595,834
Materials	932,893	754,347
Amortization	399,452	392,696
	47,986,651	43,563,986
Excess of revenues over expenses	874,440	52,115
Net assets, beginning of year	115,732	63,617
Net assets, end of year	$ 990,172	$ 115,732

See accompanying notes to financial statements.

STATEMENTS OF CASH FLOWS

Year ended March 31, 2012 with comparative figures for 2011

	2012	2011
Cash provided by (used in):		
Operations:		
Excess of revenues over expenses	$ 874,440	$ 52,115
Items not affecting cash flows:		
Amortization of deferred capital contributions (note 6)	(399,452)	(392,696)
Amortization	399,452	392,696
	874,440	52,115
Net change in non-cash working capital balances:		
Contract advances	2,479,327	(1,178,734)
Accounts receivable	197,876	325,765
GST receivable	(438,887)	(161,515)
Deposits and prepaid expenses	39,898	51,567
Inventory	(2,388)	(52,985)
Accounts payable and accrued liabilities	(1,795,502)	3,739,292
Deferred program fees	5,051	15,803
	1,359,815	2,791,308
Investing:		
Redemption of investments	44,694,115	27,706,742
Purchase of short term deposits	(5,759,672)	(2,204,822)
Purchase of capital assets	(294,224)	(1,377,980)
Deferred capital contributions	294,224	1,377,980
	38,934,443	25,501,920
Financing:		
Deferred contributions	(31,420,878)	(28,361,462)
Net increase in cash and cash equivalents during the year	8,873,380	(68,234)
Cash and cash equivalents, beginning of year	4,480,515	4,548,749
Cash and cash equivalents, end of year	$ 13,353,895	$ 4,480,515
Supplemental cash flow information:		
Interest received	$ 122,919	$ 41,401

See accompanying notes to financial statements.

NOTES TO THE FINANCIAL STATEMENTS

Year ended March 31, 2012

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:

(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 not-for-profit Corporation under the Income Tax Act (Canada) and, accordingly, is exempt from income taxes.

The Commission is funded through Contribution Agreements with Health Canada. The first agreement calls for $110 million over the five years ended March 31, 2013. As noted in above (d), the purpose of this initiative is to study best practices in addressing mental health and homelessness. The other agreements which call for $5.5 million of contributions to March 31, 2008, and $124.5 million over the nine years ending March 31, 2017, relate to the other initiatives described above. The contributions are subject to terms and conditions set out in the Funding Agreements.

2. Significant accounting policies:

(a) Financial statement presentation:
These financial statements have been prepared in accordance with Canadian generally accepted accounting principles.

(b) 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 arrangements approved by Health Canada with respect to the year ended March 31, 2012.

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.

The Commission earns service revenue related to first aid courses. Fees that are paid up front prior to the delivery of services are deferred and then recognized during the period the service is delivered.

(c) 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.

(d) Short term deposits:
Short term deposits consist of amounts held in interest bearing short-term investments, maturing within twelve months.

(e) Inventories:
Inventories are recorded at the lower cost and net realizable value, with cost determined on a first-in first-out basis.

(f) Contract advances:
Contract advances arise from commitments to service providers under direct services contracts pertaining to the Commission's research initiative for the mentally ill and homeless for services to be provided.

(g) 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
IT infrastructure	5 years
Software	2 years
Office equipment	5 years
Furniture	5 years
Leasehold improvements	over the term of the lease

(h) 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.

Realized 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 where otherwise disclosed, as at March 31, 2012, 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.

(i) 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.

(j) Future accounting pronouncements:
In December 2010, the Accounting Standards Board ("AcSB") released the accounting standards impacting the future financial reporting framework for not-for-profit Organizations. The AcSB proposes that not-for-profit Organizations select one of the two following alternatives for financial reporting:

i. Accounting Standards for Not-for-Profit Organizations along with Accounting Standards for Private Enterprises, or

ii. International Financial Reporting Standards.

These available standards are applicable to fiscal years beginning on or after January 1, 2012. The Commission has determined that it will adopt Accounting Standards for Not-for-Profit Organizations along with Accounting Standards for Private Enterprises for the fiscal year beginning April 1, 2012. Management is in the process of evaluating the impact of the adoption of these standards on the future financial statements.

3. Investments:

Investments consist of fixed income bonds issued by the Government of Canada, crown corporations and provincial governments maturing in the next year. These investments have yields ranging from 1.7% to 2.0% (2011 – 1.02% to 2.13%). The fair value of investments at March 31, 2012 is $17,727,521 (2011 – $60,661,072).

4. Capital assets:

			2012	2011
	Cost	Accumulated amortization	Net book value	Net book value
IT infrastructure	$ 492,711	$ 193,724	$ 298,987	$ 102,181
Software	202,762	198,781	3,981	13,314
Office equipment	217,717	112,474	105,243	148,787
Furniture	576,063	290,904	285,159	400,371
Leasehold improvements	1,603,118	690,011	913,107	1,047,052
	$ 3,092,371	$ 1,485,894	$ 1,606,477	$ 1,711,705

5. Deferred contributions related to operations:

Deferred contributions include operating funding received in the current or prior periods that are 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:

	2012	2011
Balance, beginning of year	$ 66,037,768	$ 94,399,231
Grants received	16,056,858	15,535,000
Less amount recognized as revenue	(47,582,964)	(42,755,781)
Amounts related to deferred capital contributions	105,228	(985,284)
Other adjustments	-	(155,398)
Balance, end of year	34,616,890	66,037,768
Current portion	34,616,890	36,558,756
	$ -	$ 29,479,012

6. Deferred capital contributions:

Deferred contributions include the unamortized portion of capital 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:

	2012	2011
Balance, beginning of year	$ 1,711,705	$ 726,421
Capital contributions	294,224	1,377,980
Amounts amortized	(399,452)	(392,696)
Balance, end of year	$ 1,606,477	$ 1,711,705

7. Commitments:

The Commission rents premises under operating leases which expire in 2016. Minimum annual rental payments to the end of the lease terms are as follows:

2013	$ 812,946
2014	456,438
2015	384,379
2016	252,425
	$ 1,906,188

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 by 2014. Obligations under these contracts are as follows:

2013	$ 30,107,103
2014	782,543
	$ 30,889,646

As at March 31, 2012, the Commission is committed to $nil (2011 – $164,056) of capital expenditures.

8. Indemnification:

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 and 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, $456,244 (2011 – $654,120) relates to accrued interest and other receivables. Included in accounts receivable is $16,939 which was incurred on behalf of a charity that supports the mandate of the Commission and whose directors and officers include the Commission's Chair and CEO. As at March 31, 2012, 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 and cash. 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. The Commission has determined that the maximum credit risk for accounts receivable is $nil (2011 – $nil), as the balance is primarily composed of accrued interest receivable from investment grade bonds rated "A" or higher.

Cash and cash equivalents consist of bank balances and short-term deposits with large credit-worthy financial institutions.

(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 $133,539 (2011 – $44,805) 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 investments. Management and the board of directors monitor capital on a frequent basis through reviewing actual to budgeted comparisons.

12. Comparative figures:

Certain 2011 comparative figures have been reclassified to conform with the financial statement presentation adopted for the current period.

ADDITIONAL MANAGEMENT INFORMATION

HOMELESSNESS SCHEDULE OF EXPENSES

For the year ended March 31, 2012

	2012
Expense by Cost Object:	
Direct client services	$ 26,556,596
Salaries and Benefits (Note 1)	1,527,164
Services	1,430,589
Travel	513,547
Occupancy	94,723
Meetings and events	201,403
Materials	40,514
Administration	2,428,358
	$ 32,792,894

Note 1:
Salaries and Benefits for the Homelessness Initiative include $170,703 for management team compensation in 2012.

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Mental Health Commission of Canada

Commission de la santé mentale du Canada