together we can

Annual Report 2010-2011

Mental Health Commission of Canada

Commission de la santé mentale du Canada

Introduction

The Mental Health Commission of Canada was created following the most important mental health study in Canadian history, during which thousands of individuals from coast to coast to coast voiced their wishes for a better mental health system.

Everyone knows that improving any system as complex and widely dispersed as the mental health system is no small feat. It requires all of us to work collaboratively, with shared goals. With our eyes on the target, it also requires us to be patient and to persevere.

The Commission is a catalyst for system and social change. We have a unique ability to bring together leaders and organizations from across the country to address the common mental health issues raised by Canadians and to accelerate change.

Our vision statement describes a society that values and promotes mental health and helps people who live with mental health problems and mental illness to lead meaningful and productive lives. Achieving that vision requires some fundamental changes to our systems of care and also to our collective way of thinking. That cannot be done by a single organization. But together we can do it. In this year's Annual Report, you will see the many ways in which we are working in collaboration with people with lived experience, mental health professionals, and a vast network of stakeholders and partners to achieve our goals.

Together we spark change

This Annual Report marks the first public appearance of the new brand identity for the Mental Health Commission of Canada.

When the Commission was created in 2007, literally around a kitchen table, developing a logo was more an act of necessity than a concerted branding exercise.

Since then, the Commission has matured into a fully functioning, diverse, and dynamic organization with a well-defined personality and strong sense of purpose. We concluded that the original logo did not truly reflect the promise of the Commission and our role as a catalyst for system and social change that leads to improved mental health for Canadians.

After a short period of work, our new brand identity emerged.

The spark—a symbol for a catalyst—is how we fundamentally view ourselves and how we would like others to see us.

The spark, with its range of colours and its sense of motion and expansion, symbolizes the transformative nature of the Commission—the sense of creating energy, of moving people living with mental health problems and illnesses out of the shadows forever and into the light of equal opportunity in Canadian society.

Each ray intersects with one another, symbolizing the collaborative nature of the Commission. After touching one other, the width of each ray increases, reminding us that working together amplifies our impact and spreads knowledge.

Dynamic, energizing, and positive, this new image is an ideal reflection of who we are, what we do, and how we do it.

Message from the Chair and President & CEO

By working together, the Commission and its hundreds of partners are helping to make mental health a priority for all Canadians.

The Vice Chair of our Board, David Goldbloom, says the Mental Health Commission of Canada is "not a Commission of inquiry, but a Commission of action" and he is absolutely correct.

In partnership with hundreds of individuals and organizations across Canada, the Commission is taking action to change the attitudes of Canadians toward mental health and mental illness and improve services and supports so that people living with mental health problems can lead fulfilling and productive lives.

The Commission and its partners know that this challenge is too great for any one organization, or any one government, to tackle alone. That is why we are united in the belief that, by working together, we can make a difference in the lives of Canadians.

The Honourable Michael Kirby is Chair of the Mental Health Commission of Canada. He retired from the Senate of Canada in 2006, after 22 years of service. Under his leadership as Chair of the Standing Senate Committee on Social Affairs, Science and Technology, the Committee produced 11 healthcare reports, including the first-ever national report on mental health, mental illness and addiction, titled *Out of the Shadows at Last,* which led to the creation of the Commission. He has been the Chair since the MHCC's inception in 2007.

Louise Bradley has been the President and CEO of the Mental Health Commission of Canada since April 2010, having spent the previous year as Chief Operating Officer. Louise began her career as a registered nurse in Newfoundland. She also studied at Dalhousie University and later obtained a Master of Science with a specialization in mental health from Northeastern University in Boston. Though her experience ranges from community mental health to forensic and corrections healthcare, she has worked primarily in the mental health field as a frontline nurse, administrator, researcher, and educator.

Photo: Cynthia Münster

Together we create change

The Mental Health Commission of Canada's mission is to promote mental health in Canada, to change attitudes toward mental health problems and to improve services and support. Youth and family caregivers are two stakeholder groups that are important partners in achieving this mission.

(L to R) Louise Bradley, MHCC President and CEO; Jack Saddleback, member of the Youth Council; Michael Kirby, MHCC Chair; and Susan Hess, member of the Family Caregivers Advisory Committee

Michael Kirby, MHCC Chair, and Louise Bradley, President and CEO, meet with Canadian Ambassador to the United States Gary Doer to discuss mental health issues at the Sixth World Conference on the Promotion of Mental Health and Prevention of Mental and Behavioural Disorders in Washington D.C. in November.

The MHCC was a partner of the Sixth World Conference on the Promotion of Mental Health and Prevention of Mental and Behavioral Disorders. MHCC Chair Michael Kirby addresses an international crowd of mental health experts at the Canadian Embassy, Washington D.C.

Louise Bradley, MHCC President and CEO, and Jayne Barker, MHCC Vice President, Research Initiatives and Mental Health Strategy, visited Fort McPherson, Yellowknife, and Inuvik to discuss mental health issues pertinent to the North.

MHCC President and CEO Louise Bradley met with Nizar Ladha, MD, and staff during a tour of the Waterford Hospital in St. John's, Newfoundland. The Waterford Hospital, which first opened in 1854, is the base of operations for the Mental Health Program of Eastern Health. Ladha is also President, Newfoundland and Labrador, and Atlantic Region Representative of the Canadian Psychiatric Association.

In 2010–11, we focused on a number of important mental health issues through our key initiatives and projects. We listened and learned from partners, generated and shared knowledge, and turned that knowledge into action to effect system and social change.

We made substantial progress on our work to develop Canada's first-ever mental health strategy. The strategy framework *Toward Recovery and Well-Being,* which the Commission released in late 2009, has already become an important reference point for mental health policy and practice across the country, and we are on schedule to release the national strategy in 2012. Implementing it will require further collaboration between all stakeholders. The Commission will be the catalyst, but everyone will have a role to play in bringing the strategy to life and ensuring it has maximum impact.

Reducing the stigma associated with mental health problems and mental illnesses is essential to building a people-centered, recovery-oriented mental health system. *Opening Minds,* the Commission's anti-stigma initiative, is collaborating today with over 70 partners across Canada to evaluate, design, and disseminate effective anti-stigma programs.

As we put the finishing touches to this annual report, we are excited to share the news that the recruitment phase has been completed for our *At Home/Chez Soi* national research project, which is looking for the best ways to provide housing and services to people who are homeless and living with a mental illness. This means that more than 1,300 people living on the streets now have a place to call home and receive the proper services and support that best correspond to their individual needs. This latest success is a direct result of the hard work and dedication of the Commission's staff and partners in the cities of Moncton, Montréal, Toronto, Winnipeg, and Vancouver.

Our Knowledge Exchange Centre (KEC) is coming closer to fruition. The KEC will be one more important way for the Commission to ensure that knowledge and best practices are widely available and shared so that everyone is better informed, empowered, and equipped to improve Canada's mental health system.

We are laying the groundwork for launching our *Partners for Mental Health* initiative in 2012—a grassroots movement committed to increasing public awareness about mental health issues through action. *Partners for Mental Health* will be a national social movement committed to positioning mental health on the national agenda, using the voices and actions of ordinary Canadians.

Our *Mental Health First Aid* (MHFA) program made significant inroads in

2010–11 in training more people to readily assist anyone who is experiencing a mental health problem or crisis. In Canada, there are now more than 460 MHFA instructors and over 40,000 people trained as mental health first aiders.

In 2010, the Commission also published several original and groundbreaking reports on issues related to child and youth mental health, workplace psychological health and safety, and peer support. These and other important reports sprang from our eight Advisory Committees, which worked tirelessly on over 20 projects during the year, all of which help inform the Mental Health Strategy for Canada. The Commission is extremely grateful to our Advisory Committees and the wide communities of experts who came together to work on these projects and continue to provide the Commission, and the entire Canadian mental health stakeholder community, with the tools and best practices they need to improve the lives of people living with mental health problems and mental illnesses.

Our progress was also advanced by the significant number of people who have experienced mental health problems, who worked directly with us over the past year. They advised us on many different levels—from helping to make report recommendations to educating us with first-person stories. We wish to thank them for their valuable contributions, which will continue to enrich our work going forward.

The Commission today has tremendous reach across the whole mental health system. Our partners include people with lived experience, caregivers, clinicians, researchers, business people, local service providers, professional associations, and all levels of government. We are speaking with and listening to all of these groups, and many more Canadians, every day. We want to acknowledge their great contribution to mental health and thank them for their collaboration, support, and encouragement.

We wish to thank the MHCC Board for its insight and guidance, and the Commission's full-time staff for all the action they have taken over the past year to create long-lasting, transformational change to the mental health system.

The time is right. We have a great window of opportunity to transform the system of mental healthcare in Canada. For the first time, governments and territories are putting mental health at the top of their agendas, and mental health issues are being discussed openly in our schools, offices, and homes. Changing the system will be challenging, but we know we can meet the challenge by working collaboratively.

As you read this report, we hope you will see opportunities where you can contribute to creating this change—one that will benefit all Canadians. Because together, we can.

Michael Kirby
Chair

Louise Bradley
President & CEO

Scan the QR code to watch videos from the MHCC YouTube Channel

MHCC Chair Michael Kirby speaks
youtu.be/Reh1o8UKlZg

MHCC President and CEO Louise Bradley speaks
youtu.be/-vb6Mcd1wj8

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Mental Health Strategy for Canada

Canada's first-ever national mental health strategy will provide a way for the people of Canada to work together to achieve better mental health outcomes and improve overall mental health and well-being.

Momentum for mental health continues to grow in Canada. The public is increasingly aware of the significance of mental health issues, and most provinces and territories are developing, revising, or implementing mental health plans and strategies. The media and the corporate sector are paying more attention to mental health. As the Commission moves closer to finalizing the Mental Health Strategy for Canada, the timing could not be better.

The impact of *Toward Recovery and Well-Being*

The Commission devoted time and resources over the past year to communicating and discussing the vision and goals set out in its 2009 *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada (the Framework)* with a wide range of stakeholders. The *Framework* has had exactly the desired effect, becoming an important reference point for many organizations and governments throughout the country as they shape their own mental health strategies, corporate plans, and programs. Here are just a handful of examples:

- In Nova Scotia, the community college in Yarmouth built the curriculum for a new two-year mental health diploma course around the goals of the *Framework.*
- In Ontario, the Ontario Shores Centre for Mental Health Sciences has used the *Framework* in its strategic planning process.
- In Quebec, the Ministry of Education has used the *Framework* as the basis for developing tools to support teachers.
- In Manitoba, the *Framework* was used as the consultation document for the development of *Rising to the Challenge*, Manitoba's five-year mental health strategic plan.
- In the corrections system at the federal, provincial and territorial levels, the *Framework* is influencing the development of a new National Corrections Mental Health Strategy.

Tackling the first-ever Mental Health Strategy for Canada

The goal for the Commission this past year has been to translate the *Framework* into the first-ever Mental Health Strategy for Canada. As we are putting the final touches to this annual report, we can share that the first draft of the Strategy identifies six strategic directions and a series of priorities for action, designed to have the highest impact and to contribute to transforming mental health systems across the country.

Strategic directions as proposed in the draft of the Strategy (subject to change):

1. Promote mental health, prevent mental illness, and intervene early in all sectors
2. *Outcome: More people living in Canada enjoy positive mental health across the lifespan.*
3. Transform relationships and uphold rights
4. *Outcome: Mental health-related policy and practice in Canada are oriented toward recovery and well-being, and the rights of people living with mental health problems and illnesses are upheld.*
5. Strengthen community capacity
6. *Outcome: People living with mental health problems and illnesses and their families have access to treatments, services, and supports in the community, as close as possible to where they live.*
7. Improve equity
8. *Outcome: Inequities in addressing mental health needs are reduced, whether based on stage of life, geographical location, diversity of background, or degree of complexity.*
9. Seek innovation with First Nations, Inuit, and Métis people
10. Mobilize leadership to fund, catalyze, and sustain the actions in the Strategy

Building on the extensive consultations that guided the *Framework* and on additional meetings held in early 2010, the MHCC brought stakeholders together and conducted an on-line survey to gather feedback on the draft of the Strategy during the summer of 2011.

Working together

While the Commission prepares the Mental Health Strategy for Canada, other organizations and governments have also been working on their own strategic approaches to addressing mental health issues in their respective jurisdictions. The Commission collaborated with a number of them to assist them in the development of their mental health plans and to learn from their experience.

(Photograph previous page)

The Provincial-Territorial Reference Group is an important resource for MHCC and its Strategy Team. Exchange of knowledge with this group for the past three years helped to shape Toward Recovery and Well-Being, the Commission's *Framework* for a Mental Health Strategy, and, for the past year, the Mental Health Strategy for Canada itself. The members provide valuable insight into the complexities of the mental healthcare system in 12 separate jurisdictions.

(L to R) Colleen Simms, Special Advisor to the Minister of Health and Community Service, Department of Health and Community Services, Newfoundland and Labrador; Paula Pasquali, Community Programs, Department of Health and Social Services, Yukon; Bruce McKee, Program Consultant Mental Health, Ministry of Health, Saskatchewan; Norman Hatlevik, Territorial Wellness Coordinator, Department of Health and Social Services, Nunavut; Susan Paetkau, Director, Health Program Policy and Standards Branch, Health System Strategy Division, Ministry of Health and Long-Term Care, Ontario; Fran Schellenberg, Executive Director, Mental Health, Addictions and Spiritual Care, Primary Care and Healthy Living Branch, Ministry of Health and Healthy Living, Manitoba; Patricia A. Murray, Executive Director of Mental Health, Children's Services and Addiction Treatment, Department of Health, Nova Scotia; Silvia Vajushi, Executive Director, Community Health Branch, Community and Population Health, Alberta Health and Wellness, Alberta; and Ann Marr, Executive Director, Mental Health and Addictions Performance Accountability, Health Authorities Division, Ministry of Health Services, British Columbia

Photo: Mélanie Provencher

Drawing on the Senate report Out of the Shadows at Last, the MHCC's *Framework Toward Recovery and Well-Being* and on the contributions of thousands of Canadians, the Mental Health Strategy for Canada will stimulate public discussion on mental health when it is released in 2012 and focus attention on how to improve mental health and well-being for everyone living in Canada.

"A mental health strategy cannot provide a magic formula that will guarantee mental health and well-being for everyone. What it can do is to set out a plan for building a genuine mental health system that will foster and nourish the strengths, capacities, and resources of people and communities, while lessening or removing the obstacles and barriers that stand in the way of achieving the best possible mental health for everyone."

Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada

(L to R) **Howard Chodos,** MHCC Special Advisor, Mental Health Strategy for Canada; **Mary Bartram,** MHCC Senior Advisor, Government Relations, Mental Health Strategy for Canada; **Jayne Barker,** MHCC Vice-President, Research Initiatives and Mental Health Strategy; **Colleen Simms,** Special Advisor to the Minister of Health and Community Service, Department of Health and Community Services, Newfoundland and Labrador; **Paula Pasquali,** Community Programs, Department of Health and Social Services, Yukon; **Bruce McKee,** Program Consultant Mental Health, Ministry of Health, Saskatchewan; **Norman Hatlevik,** Territorial Wellness Coordinator, Department of Health and Social Services, Nunavut; **Susan Paetkau,** Director, Health Program Policy and Standards Branch, Health System Strategy Division, Ministry of Health and Long-Term Care, Ontario; **Fran Schellenberg,** Executive Director, Mental Health, Addictions and Spiritual Care, Primary Care and Healthy Living Branch, Ministry of Health and Healthy Living, Manitoba; **Patricia A. Murray,** Executive Director of Mental Health, Children's Services and Addiction Treatment, Department of Health, Nova Scotia; **Silvia Vajushi,** Executive Director, Community Health Branch, Community and Population Health, Alberta Health and Wellness, Alberta; **Ann Marr,** Executive Director, Mental Health and Addictions Performance Accountability, Health Authorities Division, Ministry of Health Services, British Columbia; and **Wendy Heffern,** MHCC Manager, Mental Health Strategy

Together we transform Canada's mental health system

Howard Chodos, PhD, is Special Advisor, Mental Health Strategy, for the MHCC. Chodos has brought to the Commission extensive knowledge of mental health policies and issues. Under his leadership the Commission released *Toward Recovery and Well-Being,* a framework for transforming mental health systems across Canada. Previously, Chodos was the lead author of the final report on mental health by the Senate Committee on Social Affairs, Science and Technology—*Out of the Shadows at Last.*

Patricia A. Murray, Executive Director of Mental Health, Children's Services and Addiction Treatment, Department of Health, Nova Scotia

(L to R) Paula Pasquali, Community Programs, Department of Health and Social Services, Yukon, and Norman Hatlevik, Territorial Wellness Coordinator, Department of Health and Social Services, Nunavut

Silvia Vajushi, Executive Director, Community Health Branch, Community and Population Health, Alberta Health and Wellness, Alberta

The Commission hosted meetings with various stakeholder groups to get their feedback on the draft Mental Health Strategy for Canada. A meeting was held in Québec City with francophone stakeholders from across the country.

L to R: Mireille Bourque, painter; Stéphanie Lassonde, Mental Health Commission of Canada; Bernard Deschênes, Quebec Health and Social Services Agency of the National Capital; Diane Harvey, Association québécoise de réadaptation psychosociale; Manon Dion, Fédération des familles et amis de la personne atteinte de maladie mentale.

The Commission hosted meetings with various stakeholder groups to get their feedback on the draft Mental Health Strategy for Canada. In this picture, a meeting is being held in Ottawa with stakeholders from national health/mental health organizations.

L to R: Karen Cohen, Canadian Psychological Association; Elaine Campbell, Canadian Association of Social Workers; Joanne Jones, Canadian Federation of Mental Health Nurses; Dammy Damstrom-Albach, Canadian Association for Suicide Prevention

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L to R: David Neligan, Metropolis, Citizenship and Immigration Canada; Peter Coleridge, Canadian Mental Health Association; Jim Adamson, Schizophrenia Society of Canada

The Commission hosted meetings with various stakeholder groups to get their feedback on the draft Mental Health Strategy for Canada. In this picture, a meeting is being held in Ottawa with stakeholders from national health/mental health organizations.

L to R: Dammy Damstrom-Albach, Canadian Association for Suicide Prevention; Maura Ricketts, Public Health Group, Canadian Medical Association; Rita Notarandrea, Canadian Centre on Substance Abuse; Greg Penney, Canadian Public Health Association; Kelly Stone, Child Welfare League of Canada

Opening Minds

Through our anti-stigma initiative, we are changing the attitudes and behaviours of Canadians toward people living with mental health problems.

Many people living with mental health problems report that stigma causes them more suffering than their illness. The MHCC's anti-stigma initiative, *Opening Minds,* is working to reduce the prejudice and discrimination associated with mental illness.

Rather than re-invent the wheel, *Opening Minds* is linking arms with partners across Canada who have been conducting anti-stigma programs. Most of these programs have never been scientifically evaluated, so *Opening Minds* is studying them to determine the most effective ones and replicate them across the country. Go to http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Programs_province_Aug_2011.pdf to learn more about our partnerships.

One of the primary criteria for inclusion in *Opening Minds* is that the program must include an element of contact-based education, where people with a lived experience of mental illness share their stories and engage program participants in discussion. Contact-based education is considered to be one of the most promising practices in anti-stigma education.

And rather than address a mass audience, *Opening Minds* is using a targeted approach, currently focusing on four key audiences—children and youth, healthcare providers, the workforce, and the media.

This targeted approach, with an emphasis on contact-based education, has drawn the attention of the World Psychiatric Association, The Carter Center, and the Department of Psychology at the Illinois Institute of Technology.

Following are reports on *Opening Minds* activities in the four current target areas:

Children and youth

Opening Minds is targeting youth aged 12 to 18 years because the fear of stigma often delays diagnosis and treatment, and early intervention can make an enormous difference to recovery, as well as to quality of life over a lifetime. The initiative is also focused on changing attitudes so that youth in Canada do not grow up with stigmatizing attitudes toward people with mental health problems.

Opening Minds is currently working with 22 partners across Canada, actively evaluating 18 anti-stigma programs in this target group.

Case study

In Quebec, *Opening Minds* is working with la **Fondation des maladies mentales / the Mental Illness Foundation,** evaluating its *Solidaires pour la vie / Partners for Life* program, which is a depression awareness-raising program targeting teenagers and the parents and teachers around them. The program was created in 1998 to prevent depression and suicide among high school students in Quebec. The program has toured Quebec since 1998, giving presentations annually to an average of 60,000 students in grades 9, 10, and 11 and their parents, as well as school and local community health centre staff.

Healthcare providers

When people seek help for a mental health issue, they will almost certainly first encounter a frontline healthcare provider—from an emergency room or a family practice or a walk-in clinic. The reception they receive can either provide support and hope, or it can intensify feelings of shame, guilt, or failure.

Anecdotally, the medical frontlines are where people seeking help say they experience some of the most deeply felt stigma.

Opening Minds has been working with groundbreaking programs to help frontline healthcare providers learn more about mental health and illness, assess their own attitudes, and rethink their perspectives.

In this focus area, *Opening Minds* is currently working with 30 partners across Canada, actively evaluating 17 anti-stigma programs.

(Photograph previous page)

What better way is there to address the stigma of mental health problems and mental illness than by talking about it over coffee? In this picture, some key Quebec partners and collaborators meet at a Montréal café to discuss their respective roles in changing people's attitudes and behaviours related to mental health problems and mental illness.

(L to R) Catherine Archambault is a workshop facilitator for *Partners for Life,* a Mental Illness Foundation program that reaches 60,000 students, parents, teachers, and caregivers annually. Its goal is to prevent depression and suicide among high-school students in the province. *Opening Minds* is currently evaluating this program.

Catherine Dion is a communication specialist from Hôpital Louis-H Lafontaine in Montréal, a mental health hospital and research centre. She was instrumental in creating the web series *Clé 56,* targeted at youth. *Clé 56* was evaluated by *Opening Minds.* Results will be made public next year.

Hugues LaForce is a psychologist and project manager for the Mental Health Program at the Centre de santé et de services sociaux in Montréal. He is responsible for providing training about stigma and mental health problems to healthcare providers in his organization. He facilitated Mike Santoro's presentation this past year.

André Picard is a public health journalist from *The Globe and Mail.* He collaborates with *Opening Minds.* André talks with journalism students about the impact of words and their role in making sure that credible and objective information about mental health problems and mental illnesses is presented.

Robert Whitley, PhD, is a researcher at the Douglas Mental Health University Institute, McGill University. He has been commissioned by the MHCC to study the impact of news media and stigma. His research team is reviewing five years of newspaper articles and radio and television reports dealing with mental health problems and mental illness.

Mike Santoro is a person with lived experience who speaks publicly about his illness. Last year, he addressed some 50 healthcare workers at the Centre de santé et de services sociaux (local health agency) in Montréal, Quebec. *Opening Minds* is evaluating the impact Mike's story has on reducing stigma.

Behind the camera is Amanda Tétrault, documentary photographer and also an *Opening Minds* collaborator. At various *Opening Minds* conferences and meetings, Amanda shares the story of her father who has a mental illness and who has been living on the streets for most of his life.

Photo: Amanda Tétrault

Case studies

The first program that *Opening Minds* successfully evaluated comes from Ontario. The **Central Local Health Integrated Network (Central LHIN)** created a program called *Mental Illness and Addictions: Understanding the Impact of Stigma,* aimed at healthcare professionals in the region. The two-hour program consists of a presentation, a video addressing the issue from the perspective of people with lived experience and healthcare providers, and, lastly, contact-based education where people who have recovered talk to frontline workers about the impact stigma plays on their recovery and what helps make a positive difference.

In 2010, *Opening Minds* surveyed more than 300 healthcare professionals before and after they took the program, and preliminary results indicated that it had a significant impact in changing attitudes and behaviours of healthcare professionals—so much so that the program has been replicated and is being evaluated in British Columbia and Nova Scotia.

In 2011, *Opening Minds* will evaluate the *B.C. Practice Support Module for Family Physicians—Mental Health.* This in-depth continuing medical education accredited program has been created and is being delivered to family doctors in British Columbia. It includes contact-based education and provides new tools to doctors so they have alternative methods (other than pharmaceuticals) to treat people with mental health problems. Patients also become more involved in their treatment and recovery. One-third of British Columbia's 3,300 family physicians have received the course. Of the doctors who have taken the module, 94% say they felt the training had resulted in improved patient care and 42% say they have reduced the number of drug prescriptions they write.

Building on this promising B.C. initiative, *Opening Minds* is partnering with the Mood Disorders Society of Canada, the Canadian Medical Association, Bell, the North Bay Regional Health Centre, and AstraZeneca to develop an on-line Continuing Medical Education Program for family doctors.

Workforce

One out of every four to five employees is affected by mental health problems every year. Stigma is one of the main barriers preventing people in the workforce from seeking help. Many workers choose to go untreated rather than risk being labelled as unreliable, unproductive, and untrustworthy. The cost of doing nothing includes absenteeism, "presenteeism" (attending work when ill) and lost productivity, disability claims, injuries/illnesses, grievances, turnover, and legal liability.

Opening Minds is working with public and private sector employers to evaluate anti-stigma programs, determine which ones are effective, and replicate them elsewhere.

In this focus area, *Opening Minds* is currently working with ten partners across Canada, actively evaluating five anti-stigma programs.

Case study

In Alberta, Openings Minds is partnering with two companies to evaluate a program called *What's Up With Biff?* Developed by the **Canadian Mental Health Association—Calgary region,** this workshop targets blue-collar workforces by using video presentation, real-life case studies, and group discussion to address mental illness in the workplace.

The media

The media can have a tremendous influence on public opinion. Because the language used to describe people with a mental illness can serve to reinforce or dispel stigma and discrimination, *Opening Minds* is encouraging journalists and others to consider the impact of their words.

Scan the QR code to watch videos from the MHCC YouTube Channel

Michael Kimber at the University of King's College media symposium

http://youtu.be/Z94xofA35Y4

Opening Minds–speaking to stigma

http://youtu.be/PNLMJKNVJrc

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Journalism school symposia

In 2010–11, *Opening Minds* hosted its anti-stigma symposium at two journalism schools— Carleton University's School of Journalism and Communication in Ottawa and the University of King's College School of Journalism in Halifax.

The format for these sessions was similar to the first one that *Opening Minds* organized at Mount Royal University in Calgary in 2009. Presenters include a news reporter who speaks as a working journalist about stigma, as well as a researcher who speaks about stigmatizing language in news reports that focus on mental health and illness. Young people with lived experience of mental illness also speak to students about their mental illness, the stigma they have experienced and how it affected them, and how they now manage living with the mental illness (recovery).

Evaluating media reporting

Another important *Opening Minds* project that made significant progress in 2010–11 is a pan-Canadian media study being carried out by a research team at the Douglas Mental Health University Institute/ McGill University. They are reviewing news stories (English/French and print, radio, and television) focused on mental health and illness during the five years preceding January 1, 2010. The study, which is focusing on stigmatizing language and tone, will also continue to monitor news reports until January 2012.

Preliminary results indicate a very high level of stigmatization in Canadian news stories. The findings of this research will better inform how we approach the media regarding mental health issues. A report will be developed to educate the media and help with the development of resources for news reporters.

"Reducing stigma, eliminating discrimination, and fostering the full inclusion of people living with mental health problems and illnesses must become central to the transformation of the mental health system."

Toward Recovery & Well-Being: A Framework for a Mental Health Strategy for Canada

Together we can end stigma and discrimination

Michael Kimber, a mental health writer and advocate, speaks to first-year journalism students at the University of King's College, Halifax, Nova Scotia, during the *Opening Minds'* Mental Illness and *Stigma in News Media* symposium. Kimber, who is a graduate of the university's journalism program, was among the guest speakers invited to discuss the media's role in the perpetuation of mental health stigma.

(L to R) Amanda Tétrault, documentary photographer and family caregiver; Robert Whitley, PhD, researcher, Douglas Mental Health University Institute/McGill University; André Picard, journalist, *The Globe and Mail;* Stella Ducklow, art student with lived experience; and Michael Kimber, mental health writer and advocate

B.C. artist Niki Hylins at the Penticton Art Gallery, where she and her students showcased a series of self-portraits. Hylins shares her personal story of mental health stigma experienced from frontline healthcare workers, through workshops at B.C. Interior Health hospitals and health centres in seven B.C. communities. The overall program is being evaluated by *Opening Minds.*

Opening Minds is partnering with the University of Calgary to evaluate *The Mind Course* on its success in changing behaviours and attitudes toward those who live with a mental illness. The course combines lectures from practising psychiatrists and visits to a hospital to observe how doctors treat and interact with psychiatric patients.

(L to R) Andriyka Papish, MD, a fourth-year psychiatric resident at the University of Calgary; Lauren Zanussi, MD, a psychiatrist at Calgary's Foothills Medical Centre; University of Calgary medical student Gina Vaz

Constantin Nastic, full-time Peer Support Facilitator for the Streamlined Access Team at the York Support Services Network, and someone with lived experience of mental illness, shares his personal experience about the stigma he encountered in a healthcare setting during a workshop titled *Mental Health and Addictions: Understanding the Impact of Stigma.* The workshop is being evaluated by the MHCC's *Opening Minds* to determine its effectiveness at reducing stigma in healthcare providers.

At Home/Chez Soi

We are investigating the best ways to help people who are homeless and living with mental health issues.

At Home/Chez Soi is a national research project whose goal is to identify the best course of action to help some of our most vulnerable citizens more effectively.

The project is based on the *Housing First* approach which takes into account individual needs and choices. It entails first giving people who are homeless and living with a mental illness a place to live and then providing the necessary supports to help them stabilize their lives and recover as best possible.

At Home/Chez Soi is the MHCC's national research initiative on mental health and homelessness. The objective is to find the best strategies to help and support some of our most vulnerable citizens. It is the largest project of its kind in the world and it operates in five Canadian cities: Moncton, Montréal, Toronto, Winnipeg, and Vancouver. As of March 2011, over 1800 people have become project participants, and over 770 now have homes.

(L to R) Nicola is a person with lived experience who shares her story of mental illness and homelessness. She is a participant in the Vancouver project. Nicola is accompanied by Julian Somers, PhD, *At Home/Chez Soi* Vancouver co-researcher, and Louise Bradley, MHCC President and CEO, at an event celebrating the opening of the Bosman, a residence for participants in the *At Home/Chez Soi* Vancouver project.

Photo: Andriy Mishchenko

At Home/Chez Soi is operating in five Canadian cities—Moncton, Montréal, Toronto, Winnipeg and Vancouver—and in addition to a common research focus across sites, each site is focused on different population groups. This is the largest research project of its kind in the world, and partnership is critical to its success. Working with a large and exceptional group of partners across Canada, in 2010–11 we made significant progress—recruiting hundreds of participants from the streets and from shelters, providing them housing and supports; ensuring compliance with the *Housing First* model, improving quality, and training staff; sharing what we have learned so far; and starting work on long-term sustainability for participants.

The project teams from the five cities are reporting that participants are settling into their new homes and gaining stability in their lives. Some are forming new relationships and making use of new support systems. Some are reconnecting with family. Some are learning to grocery shop, vacuum or ride the bus. Others are pursuing jobs or opportunities to volunteer.

As encouraging as *At Home/Chez Soi* has been so far, there have also been challenges and working with very vulnerable individuals requires us to be vigilant. For example, for the participants, something as simple as learning to sleep on a bed inside a quiet apartment can be a difficult adjustment after living on the streets for years.

As a result, project teams have had to adapt and respond quickly to many twists and turns along the way, which is inevitable for an ambitious project of this scope and scale.

Integral to the operation of the project over the past year has been the guidance and advice provided by people with lived experience of mental health problems and/or homelessness. Whether through the project's National Consumer Panel (NCP), via site-specific advisory groups or in other ways, there are now more than 100 positions held by people with lived experience in the project.

The next phase of the project will bring new challenges, but will also be exciting and rewarding as we continue to make a difference in the lives of hundreds of Canadians across the country.

People who are homeless more commonly experience serious mental illness, substance abuse and challenges with stress, coping, and suicidal behaviour than the general population.

Together we can give homeless people new hope

In this photo (L to R), *At Home/Chez Soi* project leaders: Paula Goering, PhD, Research Lead; Jayne Barker, PhD, Executive Lead; Catharine Hume, Vancouver Site Coordinator; Faye More, Toronto Site Coordinator; Claudette Bradshaw, Moncton Site Coordinator; Cameron Keller, Director; Sonia Côté, Montréal Site Coordinator; and Marcia Thomson, Winnipeg Site Coordinator

Members of the *At Home/Chez Soi* Winnipeg team participate in a training session in Vancouver.

At Home/Chez Soi Executive Lead Jayne Barker, PhD, speaks at a one-year update event in Toronto.

At Home/Chez Soi national project leads and members of the Montréal Project Team meet with researchers from France who are using the same research design to create a similar project in that country. The project, named *Chez Soi D'Abord* in France, involves the cities of Lille, Marseille, Toulouse, and Paris.

This is an example of an *At Home/Chez Soi* participant residence. Participants pay a portion of their rent and are visited at least once a week by program staff. The project is all about choice, and people are able to choose housing in the cities, including apartments and group homes.

Recruiting participants

The *At Home/Chez Soi* research project aims to have a total of 2,285 homeless mentally ill people participate, with 1,325 of those receiving housing and supports.

By March 2011, all five project sites had nearly reached their enrolment targets, with more than 1,800 people recruited as project participants and close to 800 people housed (96 in Moncton, 163 in Montréal, 175 in Toronto, 119 in Winnipeg, and 220 in Vancouver).

With nearly the full number of participants recruited, the five sites began to plan for the next phase of the project, which includes an increased focus on supporting individuals in their ongoing recovery.

"You don't know how much hope means until you have none. This [project] kinda gives me hope."

At Home/Chez Soi participant

Improving quality

Over the past year, project leaders visited all five sites to ensure that the project protocol was being consistently implemented and to address any emerging issues. On-site training was put in place to help project teams deal with the challenges that naturally arise when providing services to vulnerable individuals.

The second annual national training event took place in Moncton in June 2010 and a third one took place in Vancouver in May 2011. These events provide training for close to 200 frontline staff. For example, there are opportunities to share ideas about how best to support participants so that they can maintain their apartments in an expected condition or how to help them develop necessary life skills to increase their chances of successful independent living.

Sharing information

Members presented at local and international conferences and engaged in various knowledge exchange activities including several communities of practice. These groups allow people providing similar services across the sites to share experiences and to learn from one another. Internal and external update bulletins were also produced.

Early Findings Report

The *At Home/Chez Soi* project team has compiled its first Early Findings Report through which it will share project knowledge on an ongoing basis with community partners and other interested people. While it is too early to report consistent outcomes, future reports–which will be updated and released quarterly–will start to provide a more complete and meaningful picture of our learning as the project progresses.

Media interest

The media continued to be interested in the progress of the project, which resulted in several reports over the past year, including a five-site Radio-Canada television and radio update about the project and a series of feature articles in the *Vancouver Sun* daily newspaper.

Documentary

The MHCC also worked in 2010–11 on a plan to produce a video documentary about *At Home/Chez Soi* and continues to discuss the possibility with a Canadian production partner.

One-year update events

A series of one-year update events were held in Vancouver, Moncton, Toronto, and Winnipeg in 2010–11. These community events were open to *At Home/Chez Soi* partners, the public, and the media, and provided opportunities to report on project progress and for local project teams and partners to get together and celebrate milestones. There was a great atmosphere of accomplishment at each of the events.

International interest

At Home/Chez Soi is capturing the attention of stakeholders in both Canada and abroad.

Over the past year, the project team shared what has been learned with

Homelessness in Vancouver declines

Results from the 2011 Metro Vancouver homeless count show the City of Vancouver experienced an 82% reduction in street homeless since the last count in 2008 and a further 6% reduction in overall homelessness since 2010, the last time Vancouver conducted its own count. City housing staff cited *At Home/Chez Soi* as one of several key factors in the sharp decrease in Vancouver homelessness.

Scan the QR code to watch videos from the MHCC YouTube Channel

At Home/Chez Soi: Toronto participant Isaac says project has changed his life

http://youtu.be/NzyFR_iO438

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other Canadian jurisdictions and with countries such as France, Australia and Portugal.

In 2010, *At Home/Chez Soi's* Montréal team welcomed a delegation from France that plans to implement a version of the research project in Toulouse, Lille and Marseille in 2011 and in Paris in 2012.

Discussions about sharing with additional countries are underway.

"I wish more people were able to get into this project. It's helped so many people, and it's helped me a lot, too."

At Home/Chez Soi participant

Research

Regarding data collection, the *At Home/Chez Soi* team developed new research scales to rate the quality of housing for project participants, as well as measure the impact that adverse childhood events have had on participants, which is important to know for policy and practice purposes, and, most importantly, for increasing public understanding of the path to homelessness.

Project team members also developed guidelines and suggestions to help project participants and the media interact in the best way.

"Everyone that I've come into contact with [through the project] has been really supportive and treated me like a human…I've never really felt like that before."

At Home/Chez Soi participant

Sustainability

Sustainability planning for *At Home/Chez Soi* is a high priority.

We are often asked, "What will happen to the participants when the research project ends?"

Sustainability is something we have been talking about and planning for since the beginning of the project. Over the past year, a cross-site committee took the lead on this work. *At Home/Chez Soi* and the Commission continued to liaise closely with our partners—including governments, funders and many other stakeholders—with a view to a transition plan for project participants. Our objective is to make sure participants involved in the *At Home/Chez Soi* project have places to live and the necessary supports at the end of the project. In addition, we want to make sure that the research findings are used to inform public policy in the area of homelessness.

"There are many forms of discrimination. It can be overt and direct, involving the exercise of power over people, as when people living with mental health problems or illnesses are denied employment or housing opportunities or access to homecare. And it can take the form of simply avoiding contact with them."

Toward Recovery & Well-Being: A Framework for a Mental Health Strategy for Canada

At Home/Chez Soi Toronto participant, Isaac, speaks about his experience in the program during a one-year update event in Toronto.

Members of the *At Home/Chez Soi* Winnipeg's Lived Experience Circle, which provides culturally sensitive advice and guidance to the local project team

Furniture is moved into an *At Home/Chez Soi* participant residence. In February 2008, the federal government allocated $110 million to the Mental Health Commission of Canada to find ways to help the growing number of homeless people who have a mental illness. The research projects are scheduled to end in 2013.

Knowledge Exchange Centre

The Mental Health Commission of Canada's Knowledge Exchange Centre has focused on building a strong, evidence-informed foundation to guide its future work.

Over the past year, we successfully designed and implemented an activated knowledge exchange framework. The framework shifts away from the traditional model of communication (researchers with policy-makers, care providers with people with lived experience) to one that recognizes the value of knowledge that is created when multi-directional dialogue is facilitated among all of the constituents.

The Knowledge Exchange Centre is built around the concept of conversations through which knowledge is exchanged. In this photo, Dan Bilsker, PhD, psychologist at Simon Fraser University in British Columbia and senior consultant at the MHCC, and Victoria Jeffries, doctoral student in Health Sciences at SFU and project manager for the Consumer/Peer Research Network Development project at the MHCC, discuss the objectives and appropriate methodology of a research review.

Photo: Greg Ehlers

The second major piece of work completed in 2010–11 was a scoping review of existing knowledge exchange initiatives in the Canadian mental health community. It is essential to understand the existing landscape, identify where there are opportunities to leverage existing initiatives, and highlight potential partnership and collaborative opportunities.

Finally, the Knowledge Exchange Centre created a digital knowledge exchange infrastructure. It researched, designed, and implemented a number of innovative web tools and functions to promote enhanced knowledge exchange among our key stakeholder groups. In 2011–12, these will be rolled up and incorporated into the larger MHCC website to ensure that there is an increased ability to engage and interact.

Scan the QR code to watch videos from the MHCC YouTube Channel

The Activated Knowledge Exchange *Framework* of the Knowledge Exchange Centre of the Mental Health Commission of Canada

http://youtu.be/B4lhhMCrg2s

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"By facilitating the sharing of information across geographical and jurisdictional boundaries, it will be possible for everyone in Canada to benefit from existing research and to learn from successful and emerging programs."

Toward Recovery & Well-Being: A Framework for a Mental Health Strategy for Canada

Together, we share knowledge to accelerate change

Victoria Jeffries, (right) doctoral student in Health Sciences at SFU and project manager for the Consumer/Peer Research Network Development project at the MHCC, and Dan Bilsker, PhD, psychologist at Simon Fraser University in British Columbia and senior consultant at the MHCC, share knowledge and exchange ideas about mental health at Simon Fraser University in B.C.

Part of the Mental Health Commission of Canada's mandate is to share knowledge to accelerate change within the mental health system. The MHCC was a major sponsor of the Sixth World Conference on the Promotion of Mental Health and Prevention of Mental and Behavioural Disorders in Washington D.C. in November 2010. International leaders in mental health met to learn about research findings and programs that promote mental health across the globe.

Robert Whitley, PhD, a researcher at the Douglas Mental Health University Institute/McGill University, speaks to first-year journalism students. Whitley was a keynote speaker at the University of King's College in Halifax, Nova Scotia, during the *Opening Minds' Mental Illness and Stigma in News Media Symposium.* He has been commissioned by the MHCC to study the impact of news media on mental illness stigma. His research team is reviewing five years of newspaper articles and radio and television reports dealing with mental health problems and mental illness.

(L to R) Amanda Tétrault, documentary photographer and family caregiver; André Picard, journalist, *The Globe and Mail;* Stella Ducklow, art student with lived experience; Michael Kimber, mental health writer and advocate; Romie Christie, MHCC; and Robert Whitley, PhD, researcher, Douglas Mental Health University Institute/McGill University

Partners for Mental Health

We are getting ready to launch a grassroots movement to position mental health on the national agenda and promote the power of mental well-being.

Given its 10-year mandate, the Commission is seeking ways to ensure the changes that are made during its lifespan are sustained indefinitely.

One way we plan to do that is through *Partners for Mental Health,* a grassroots movement that will play an increasingly important role in the Commission's long-term sustainability plan when the movement is officially launched in 2012.

The Commission was established in 2007 following the most important mental health study in Canadian history, during which thousands of individuals from coast to coast to coast voiced their desire for a better mental health system and which culminated in the Senate report *Out of the Shadows at Last*. This massive public consultation project recognized the need for Canadians to rally behind this cause proudly and openly, much like millions of Canadians have for other illnesses.

The suicide of Queen's University student Jack Windeler affected his family, friends, and the entire university campus. Those friends worked with Jack's father, Eric, to found *The Jack Project,* which supports youth as they transition from late high school into their years of college, university, or independent living, helping them to achieve and sustain optimal mental health.

Photo: Greg Black

In recent years, more and more Canadians have shown their willingness to speak publicly about mental health and mental illness. With well-known Canadians such as Michael Wilson, Bob Rae, and Margaret Trudeau sharing their experiences of mental health problems, and with celebrities such as six-time Olympic medalist Clara Hughes participating in the Bell *Let's Talk* campaign to raise awareness about mental health, it is clear that a positive change in attitudes is afoot.

And, encouragingly, that change is being driven by "ordinary Canadians" too. For example, when Eric Windeler's son Jack died by suicide during his first year at university, Eric created *The Jack Project* to foster discussion and support for young people who are moving into the world of adulthood—a time when many mental health issues first emerge. And when 14-year-old Daron Richardson died by suicide in Ottawa, her parents helped to create the *Do It for Daron* campaign to raise awareness of mental health issues for young people.

These are the sorts of grassroots initiatives that *Partners for Mental Health* will seek out and help. We believe that just as *Out of the Shadows at Last* recognized the call for change, *Partners for Mental Health* will be able to amplify it.

2010–11 was a year of preparation for *Partners for Mental Health.* The Commission worked to develop a communication strategy and a set of tactics for the initiative as it gets ready to launch publicly next year. Partners will be working "on the ground," which means working directly and energetically with the dedicated individuals and organizations like the Canadian Mental Health Association, who have worked tirelessly for years to improve Canada's mental health system and services.

"The Commission is calling for the entire mental health community to join together and launch a social movement from coast to coast to coast that can successfully engage all people living in Canada."

Toward Recovery & Well-Being: A Framework for a Mental Health Strategy for Canada

Together we can put mental health at the top of the national agenda

Friends of Jack Windeler hold up a framed photo of the former Queen's University student. Jack's friends worked with his father, Eric, to found *The Jack Project,* which helps youth achieve and sustain optimal mental health.

Jack Windeler's friends had T-shirts made to support *The Jack Project,* which helps youth as they transition from late high school into their years of college, university, or independent living.

Eric Windeler holds a framed photo of his son Jack.

The stories of Megan Schellenberg and Luke Richardson

Just as the richest soil can be found where volcanoes loom, often mental illness or a tragic loss can be the medium for a fertile and important social movement. Here are two examples. The Commission is working with some of these grassroots initiatives and hopes to work with these and many more through *Partners for Mental Health.*

Megan Schellenberg, a young First Nations woman from northern Ontario, has used her own struggles with self-harm, depression, and suicidality to become a member of the Commission's Youth Advisory Committee and a respected advocate for the prevention of suicide by Aboriginal youth. She has written for CBC.ca and for media in British Columbia about her struggle, the struggles of others, and possible solutions.

The suicide of Ottawa native Daron Richardson caused ripples of shock in eastern Ontario. Daron's father, Luke, a member of the coaching staff of the NHL's Ottawa Senators, decided to speak out and his message spread across Canada instantaneously. The Do it for Daron campaign has people of all ages and from all walks of life engaged in fundraising and educational events dedicated to Daron's memory and the discussion of mental health among adolescents.

Mental Health First Aid

We are helping Canadians recognize and manage mental health problems in themselves and others.

The term "*Mental Health First Aid*" refers to the help provided to a person developing a mental health problem or experiencing a mental health crisis.

First developed in Australia in 2001, the *Mental Health First Aid* (MHFA) training course was introduced in Canada in 2006 and came under the leadership of the Commission in April 2010.

Our MHFA program provides people with the skills and knowledge they need to better manage a mental health crisis or mental health problems in themselves, a family member, a friend, or a colleague. By increasing mental health literacy and awareness, the program also supports the Commission's efforts to reduce stigma and discrimination experienced by people living with mental health problems and mental illnesses.

Mental Health First Aid (MHFA) educates participants about skills for providing early support, which are so important when someone is suffering from a mental health problem or experiencing a mental health crisis. Participants are then able to take what they have learned and teach MHFA to others. They are among the 40,000 mental health first aiders across Canada who can help friends, family, colleagues, or even a stranger. MHFA proudly expanded its reach across the country this year, offering courses in Iqaluit, Nunavut, for the first time ever. Participants in Iqaluit, including those in this photo, were instructed by Irene Fraser.

(L to R) Miali Dimitruk, Government of Nunavut Department of Justice in Cambridge Bay; Al Hartley, Government of Nunavut Department of Justice; Maxine Carroll, Akausisarvik Mental Health Treatment Centre; Mona Autut, Government of Nunavut Health and Social Services in Baker Lake; Jennifer Kotab, Nunavut Women's Correction Center; and Jillian Sparrow, Nunavut Women's Correction Center in Iqaluit.

Photo: Tom Short

Together we can improve mental health literacy

Mental Health First Aid Basic Instructor training given by Keith Turton, Halifax, Nova Scotia

(L to R, top row) Jade Mahoney, Julie Crouse, Steven Gaulton, Mabelann Kosick

(L to R, bottom row) Trix Van Egmond, Kathy Cutler, Karon Ann Parsons

Mental Health First Aid Youth Instructor training given by Keith Turton, Kingston, Ontario

(L to R, top row) Joanne Erasmus, Lynda Perry, Carla Abichahine, Beth Doxsee, Mike Condra, Janet Marmur, Hazel Nerysoo, Rita Green, Stacey Kiefer, Edward Wright

(L to R, bottom row) Peggy Day, Elliot Embury, Susan Peffer

Mental Health First Aid Basic Instructor training given by Karen Kyliuk, Winnipeg, Manitoba

(L to R, top row) Brian Yuzdepski, Sharon Flatten, Sandra Wallace, Jaret Moshenko, John Mayo

(L to R, bottom row) Karen Kyliuk (instructor), Rebecca Sourisseau, Carla Eckstrom, Caroline Fenney, Charlene Eckstrom, Adrienne Fillatre

Mental Health First Aid Basic Instructor training given by Irene Fraser in Iqaluit, Nunavut

(L to R) Caroline Anawak, Government of Nunavut Health and Social Services; Mona Autut, Government of Nunavut Health and Social Services; Irene Fraser (instructor), Government of Nunavut Health and Social Services; Maxine Carroll, Akausisarvik; Miali Dimitruk, Department of Justice; Jennifer Kotab and Jillian Sparrow, Nunavut Women's Correction Center; and Al Hartley, Department of Justice

Jillian Sparrow (left) and Jennifer Kotab, colleagues at the Nunavut Women's Correction Center in Iqaluit, discuss their *Mental Health First Aid* training session.

Mental Health First Aid does not teach people how to be therapists. It does, however, teach them how to:

- recognize the signs and symptoms of mental health problems;
- provide initial help; and
- guide a person toward appropriate professional help.

MHFA offers two courses: a basic course aimed at adults and a separate course for adults who interact with youth aged 12 to 24 years. Instructor training is available to qualified individuals.

Since MHFA became a Commission program in early 2010, the number of mental health first aiders across Canada increased by 114% (from 19,000 to more than 40,000) and the number of instructors trained increased by 86% (from 250 to 465). As a result, the MHFA course is now offered in all Canadian provinces and territories.

Programming tailored to meet the needs of Canadians

MHFA is open to members of the general public aged 18 years and older. Groups that have already benefited from MHFA include families, teachers, health service providers, emergency workers, frontline service providers who deal with the public, volunteers, human resources professionals, and community agencies.

MHFA is also taught in workplaces, at universities and colleges, at correctional institutions, and to municipal, provincial, and federal government employees.

MHFA programs are being adapted and delivered in Canada's North—the Northwest Territories, the Yukon and Nunavut—with specific content and teaching approaches to meet the learning needs of Inuit and other Canadians living in the region.

The French version of MHFA is named *Premiers soins en santé mentale.* In 2010, the French website went live and bilingual instructors delivered courses in French in Alberta, Nova Scotia, and the Yukon. The francophone school board in Alberta now has MHFA instructors who are delivering the program to all teachers and other school personnel in the province's 14 francophone schools.

MHFA Canada strives for continuous improvement. MHFA has already been thoroughly evaluated in Australia and its effectiveness at reducing stigma has been demonstrated. Evaluations in Canada have been ongoing and now MHFA is working with *Opening Minds,* the Commission's anti-stigma initiative, to continue evaluating the effectiveness of MHFA programming in changing the attitudes and behaviours of people toward those suffering from mental health problems and mental illnesses.

Looking forward

New initiatives are underway for 2011–12 to bring the training to new audiences:

- In Quebec, la Fondation des maladies mentales/the Mental Illness Foundation will send staff for instructor training in order to deliver MHFA for adults who interact with youth to almost 700 schools across the province.
- MHFA received a grant from Health Canada to restructure and adapt MHFA for First Nations peoples in ways that are respectful and strengths-based, recognizing the importance of early and ongoing engagement of First Nations people in the design, content, and implementation of the MHFA pilot. There are cultural ways of being, knowing, and viewing the world, including personal and professional conceptualizations of mental health and mental illness. Traditional healing paradigms of First Nations and healing modalities appropriate to First Nations' historical and current contexts will be central to the restructuring.
- Trillium Health Centre, with locations in Mississauga and Toronto, and one of Canada's largest academically-affiliated health centres, has asked MHFA to adapt the training course for seniors. A proposal has been submitted and discussions are in progress.
- MHFA for Youth Peer-to-Peer is in development in Australia at the Orygen Research Centre, University of Melbourne. MHFA Canada and the Commission's Youth Advisory Council members participated in an international Delphi study. The program is being field tested and evaluated, with publication scheduled for late 2011. This program will be available to MHFA Canada for adaptation to Canadian youth in early 2012.

"A mental health strategy cannot provide a magic formula that will guarantee mental health and well-being for everyone. What it can do is to set out a plan for building a genuine mental health system that will foster and nourish the strengths, capacities, and resources of people and communities, while lessening or removing the obstacles and barriers that stand in the way of achieving the best possible mental health for everyone."

Toward Recovery & Well-Being: A Framework for a Mental Health Strategy for Canada

Scan the QR code to watch videos from the MHCC YouTube Channel

Mental Health First Aid–Karen Kyliuk, Part One

http://youtu.be/mTGqzgv4ZWM

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Child and Youth Advisory Committee

"The opportunity to prevent mental health problems and illnesses appears to be greatest among children and youth. Early intervention offers an opportunity to address problems before they become entrenched."

Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada

Keli Anderson (left) is the Executive Director of The F.O.R.C.E. Society for Kids' Mental Health, Co-founder of the National Institute of Families for Child and Youth Mental Health, and a Parent Member of the Child and Youth Mental Health Advisory Committee. Megan Schellenberg (right) is a member of the MHCC's Youth Council. They came together in May in Vancouver, B.C., at an event raising public awareness and support for National Child and Youth Mental Health Day.

Photo: Andriy Mishchenko

At any given time, approximately one in five Canadian children and adolescents are experiencing some form of mental disorder, and for more than 70% of adults living with mental health problems, symptoms of the onset of illness occur in childhood or early adolescence.

Over the past year, the Commission's Child and Youth Advisory Committee (CYAC) continued its work on a wide range of projects designed to help children and youth at risk—by attempting to improve their life trajectories and reducing the prevalence of mental health problems in adulthood.

Evergreen Framework: In July 2010, the CYAC published the *Evergreen Framework,* which sets out a vision for child and youth mental health in Canada that complements—and providesa child and youth context for—the national mental health strategy being developed by the Commission.

Arising from a consultation process involving professionals, youth, parents, and members of the public from across Canada, as well as contributions from national and international advisory committees, the *Evergreen Framework,* a non-prescriptive document, is designed to:

- be available to governments and organizations interested in developing mental health policies, plans, programs, and services for children and youth;
- stimulate dialogue among young people, parents, service providers, service users, and the wider public on what they can do to support child and youth mental health across Canada and also on which types of services they should have a right to; and
- provide the Commission with information it can use to support its national mental health strategy.

A knowledge exchange and dissemination plan is under development for implementation in 2011.

Youth Council: The CYAC has established a Youth Council of Canadians between the ages of 17 and 29 who have first-hand experience with mental health problems, either personally or within their families. The Youth Council is ensuring that the voice of Canadian youth is heard and represented in the overall work of the Commission. Members of the Youth Council contributed to the development of the *Evergreen Framework* by preparing and implementing a youth engagement strategy that included on-line networking and the use of social media (e.g. Facebook).

Parenting Skills for Promotion of Adolescent Mental Health: We want to make it easier for parents of preteens and teens to seek help and information, increase their knowledge of adolescent mental health and parenting strategies, and become

Together we can help improve the mental health of young Canadians

Members of the MHCC's Child and Youth Mental Health Advisory Committee

Members of the MHCC Youth Council meet in Ottawa in February 2011.

(L to R, top row): Tanya Jorgensen, Simran Lehal, Megan Schellenberg, Kyle Haddow, Kristen Grout

(L to R, bottom row): Jack Saddleback, Mo Khan (former member), Faye Bonjte, Aaron Goodwin, Shawn Akiainnuksuk (former member)

Geoff Couldrey, MHCC Vice-President, Knowledge and Innovation, wears a green ribbon supporting National Child and Youth Mental Health Day at an event in Vancouver in May. The event was organized by the Institute of Families for Child and Youth Mental Health. Co-founder of the Institute, Keli Anderson, is a parent member of the Child and Youth Mental Health Advisory Committee, and Executive Director for The F.O.R.C.E Society for Kids' Mental Health.

Child psychiatrist Simon Davidson, MD, (left) is the Chair of the MHCC's Child and Youth Mental Health Advisory Committee and the Executive Director of the Provincial Centre of Excellence for Child and Youth Mental Health, Children's Hospital of Eastern Ontario (CHEO), Ottawa. He and McGill University medical student Amanda Angelus (right), a member of the MHCC's Youth Council, sat down in Ottawa to discuss the *Evergreen Framework.*

Evergreen provides a framework of values and strategic directives to assist governments and other authorities in addressing child and youth mental health services and support.

informed about early signs of mental health problems. Launched through a grant, this project aims to develop a family-centred framework that will outline accessible, adaptable, and engaging approaches to educating parents. Over the past year, a project committee was formed and a research team was selected. A literature review, an environmental scan, and focus groups of parents are planned for 2011.

School-Based Mental Health and Addictions Services Research: Many child and youth mental disorders begin when young people are in, or entering, junior high, high school, or university. This project is designed to provide practitioners and policy-makers in education, health, child welfare, and related organizations and agencies with a variety of policy and practice options to help deliver school-based mental health and addictions services. An extensive literature review, a scan of innovative practices across the country, and a national census of public schools documenting current practices continued in 2010 and are expected to be completed by late 2011. Knowledge transfer and exchange activities, including a symposium bringing together leaders in the area, are also being planned.

Family Unit Self-Stigma: Stigma directed inwards, toward oneself, or received from members of one's family can worsen one's mental disorder and impede recovery. Through this project, CYAC is developing a new initiative to address child and youth self-stigma, as well as self-stigma within a family unit, including parents, siblings, and other family members and caregivers. The project is identifying needs and effective strategies for understanding and tackling self-stigma. Data is being collected through focus groups that include youth and family members. A team of youth was recruited in 2010 to help researchers explore the issues of self-stigma.

Child and Youth Mental Health Knowledge Mobilization: With this project, CYAC is aiming to inform and engage youth—and those who care for and work with them—by creating ways of sharing information on topics related to child and youth mental health. An environmental scan titled *Digital Playgrounds: Popular Social Media Sites and Their Relevance for a Knowledge Mobilization Strategy in Child and Youth Mental Health* was published in 2010. Also in 2010, groups were selected, as partners, to conduct youth focus groups, which are being asked to determine the best avenues for developing a set of technology-based tools for youth (e.g. websites or social networking tools). In early 2011, the project committee also contracted a research firm to carry out a concurrent assessment of the mental health information needs of youth (e.g. types of information, resources they are seeking, use of language).

Scan the QR code to watch videos from the MHCC YouTube Channel

Child and Youth mental health issues: a discussion

http://youtu.be/QXKVxxtOr18

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Family Caregivers Advisory Committee

"There is substantial research evidence to suggest that enhancing the competence of family caregivers in their daily responsibilities—by providing information and education and by helping them to improve their communication skills and problem-solving capacities—can have an impact on the course of mental illness, at least by helping to delay relapse and hospitalization. Unfortunately, family members have often been marginalized by the mental health system."

"The impact of mental health problems and illnesses on family caregivers cannot be overestimated. Lives can be overtaken by grief and distress. What is more, stigma may generate a tremendous sense of unwarranted shame and guilt, which can undermine caregivers' confidence and well-being and have a long-lasting impact."

Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada

The Family Caregivers Advisory Committee's mission is to help create conditions that will promote full and meaningful lives for people diagnosed with mental illness and for their families and friends, who often serve as the primary support network.

(L to R) Maritza Tello, Elizabeth Nickason, Joyce Smith, Clem Martini, Susan Hess, Eugene Niles, Judy Gold, Ella Amir, Christina Martens, and Nérée St-Amand

Photo: Brian Dupuis

It is estimated that 2% of adult Canadians are currently providing care to a family member, friend, or neighbour who is diagnosed with a mental illness. That translates into approximately 700,000 caregivers nationwide.

The vision of the Family Caregivers Advisory Committee (FCAC) is that families and other supporters will be provided with all the relevant information, education, guidance, and support needed, in a culturally sensitive way, so they can best help ill relatives throughout the course of an illness and at the same time maintain the integrity of their own well-being.

Mental Health Family Link: During 2010, the FCAC continued its work to develop a virtual peer support program for family caregivers, where those who have cared for a family member living with a mental health problem or illness provide peer support by telephone for other families in similar circumstances. A scan of similar programs, a literature review, and a draft training manual have been prepared. The project was put on hold in mid-2010 and opportunities to build on the existing work of the project are under consideration.

The FCAC strongly believes in the value of connecting family caregivers in need with trained peer support volunteers who have "been there" and can provide support through lived experience. The committee will continue to advocate for support for such programming.

Together we can educate and support caregivers

The Family Caregivers Advisory Committee ensures the MHCC's work prioritizes the entire family of a person with a mental illness.

(L to R) Joyce Smith and Ella Amir, MHCC Family Caregivers Advisory Committee, and Ken Smith.

First Nations, Inuit and Métis Advisory Committee

"A mental health strategy for Canada must acknowledge and respond to the unique circumstances and contributions of First Nations, Inuit, and Métis in Canada. This is important not only for First Nations, Inuit, and Métis themselves but also for everyone living in Canada."

Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada

The First Nations, Inuit and Métis (FNIM) Advisory Committee is focused on promoting overall mental health and well-being among Indigenous people living in communities on and off reserves in Canada. The Committee wants to help increase knowledge and understanding with respect to issues of cultural safety, social justice, ethical accountability, and diversity competency. In this photo, a group of Committee members and partners are joined by graduates of the University of Victoria Master of Education in Counselling for Aboriginal Communities program during a graduation celebration outside the Songhees Nation Big House in Victoria, B.C.

(L to R) Lorna Williams, PhD, University of Victoria; Terry Adler, FNIM Advisory Committee; Bill Mussell, FNIM Advisory Committee; Jennifer White, PhD, FNIM Advisory Committee; Ruby Isaac, graduate; Nella Nelson, Native Mental Health Association of Canada; and Gina Robertson, graduate

Photo: Michel Joffres

The First Nations, Inuit and Métis Advisory Committee (FNIMAC) is dedicated to providing advice regarding Aboriginal mental health by collaborating with Aboriginal people, communities and agencies, and is working to increase well-being among Indigenous people living on and off reserves in Canada.

The FNIMAC, which includes First Nations, Inuit, and Métis members, as well as others who work in Indigenous health, is aiming to increase knowledge and understanding with respect to issues related to Aboriginal mental health. By early 2011, the FNIMAC was close to completing two major projects, as follows.

Cultural Safety: The concept of cultural safety encourages service providers to take social, political, linguistic, and spiritual realities into account. The FNIMAC's cultural safety research project is focused on Indigenous people and those providing services to First Nations, Inuit, and Métis people living with mental health problems and illnesses. Its purpose is to demonstrate how the application of cultural safety as a value, principle, and practice will assist individuals, families, and communities of diverse cultures to experience more positive outcomes when accessing mental health resources and services. The project is also aimed at ensuring that cultural safety informs all efforts of the Commission and becomes a pillar of the Commission's work on developing a national mental health strategy and the *Opening Minds* anti-stigma initiative.

During 2010–11, two literature review papers were completed—one providing a critical overview of cultural safety and the other focused on social inclusion. In addition, focus groups were held across Canada to explore the concept of cultural safety, and the data has been analyzed and summarized by the researchers. In June 2010, a gathering was co-hosted in Calgary by the Tsuu T'ina Nation and the FNIMAC to test what was learned through the focus groups. A secondary analysis of the data was conducted by research assistants at the University of Saskatchewan, and the data was compiled in a final report that is expected to be released in 2011. An interim report, called *Holding Hope in Our Hearts: Relational Practice and Ethical Engagement in Mental Health and Addictions, Background Paper,* was released in November 2010.

A Cultural Safety Curriculum on cultural safety and cultural competence education called *One Focus; Many Perspectives* was piloted at various levels within the Commission itself in early 2011. Related materials are expected to be completed by mid-2011. The Curriculum includes a component on stigma and stigmatization. A Cultural Safety DVD called

Together we can build a mental health system that responds to the needs of Indigenous peoples

Members of the MHCC's First Nations, Inuit and Métis Advisory Committee

Some Advisory Committee members may be missing from the photo.

Graduates inside the Songhees Nation Big House in Victoria, B.C., celebrate their successful completion of the Master of Education in Counselling for Aboriginal Communities program from the University of Victoria.

Lorna Williams, PhD, (left) Canada Research Chair in Indigenous Knowledge and Learning, speaks at the graduation celebration of the Master of Education in Counselling for Aboriginal Communities program from the University of Victoria. The first of its kind in the country, this program, developed by Williams, offers a better way to educate counsellors in both Indigenous and Western approaches to emotional and psychological healing. She is joined by Terry Adler (middle) and Bill Mussell (right).

Family, friends, and supporters gather outside the Songhees Nation Big House in Victoria, B.C., to congratulate the graduates of the Master of Education in Counselling for Aboriginal Communities program. This University of Victoria program has provided the graduates with the necessary background to offer culturally responsive counselling to Aboriginal communities.

Glimpses of Light was also completed in 2011 and brings the concept of cultural safety to life through the voices of people living with mental health problems. Additional materials that can be used for training purposes, as well as a plan for the design and implementation of education sessions, are currently being developed.

Ethical Guidelines: This research project is developing an ethical framework to guide frontline prevention, promotion, and intervention programming and services delivered to First Nations, Inuit, and Métis communities. While having broad application across the healthcare and social service fields, the work is focusing mainly on the application of an ethical framework for mental health and addictions frontline program and service delivery, where some of the most vulnerable Indigenous people seek support.

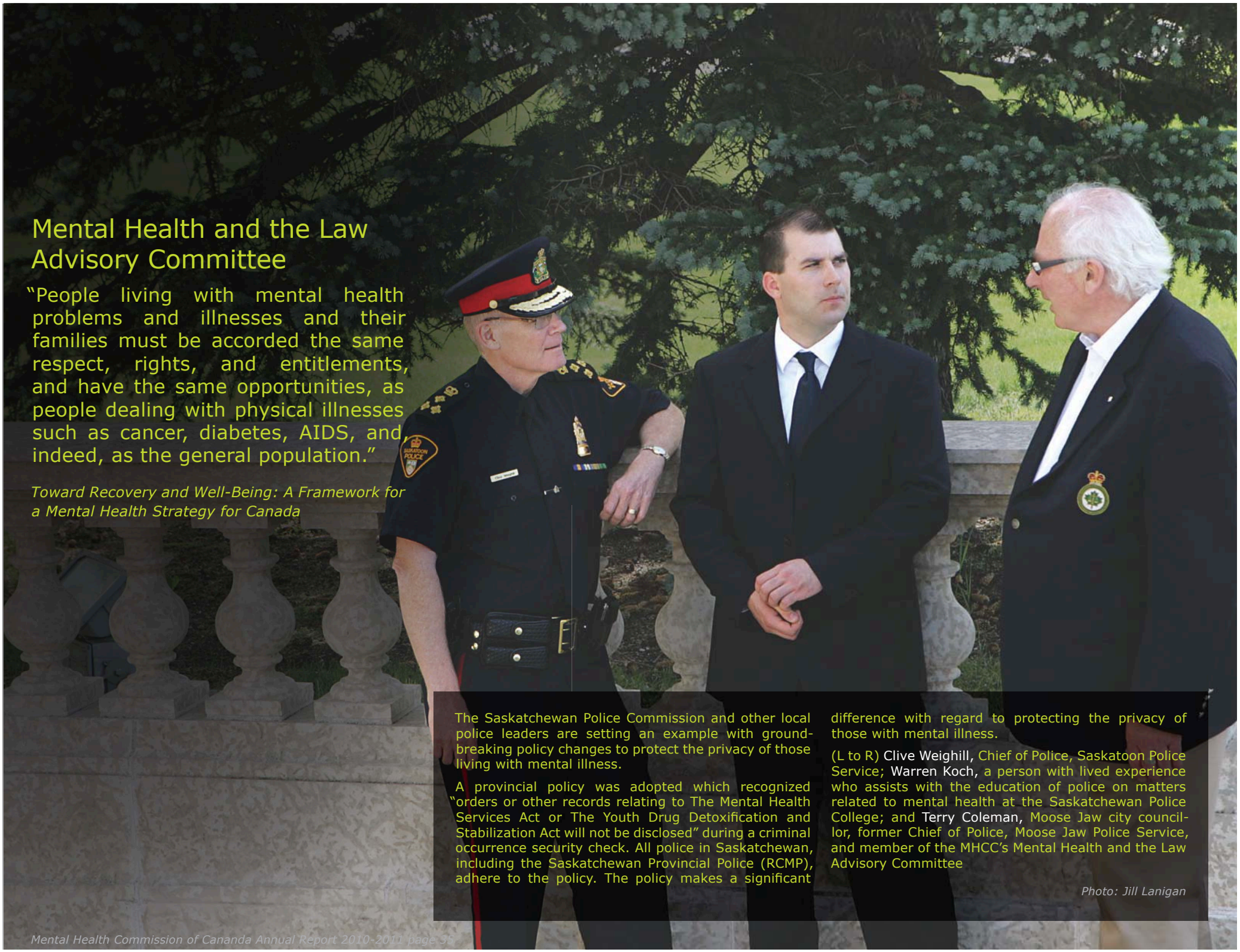
A national roundtable consultation for this project took place in Saskatoon in late 2009 and involved 65 participants from across the country. The roundtable was funded by the First Nations, Inuit & Aboriginal Health Branch of Health Canada. Also, a literature review was completed and two background papers written—one providing an overview on ethics and ethical frameworks, with a focus on population and public health, and the other one exploring the concept of, and calling for the creation of, an "ethical space" in which local Indigenous world views, including ideas of moral responsibility, are given consideration equal to that given to Western ethical principles. The Ethical *Framework* final report is expected to be available by mid-2011.

Work continued during 2010–11 on a related documentary film, designed for teaching purposes, on the role of ethics in the delivery of mental health and addictions services to Indigenous peoples. This film will be one of the materials incorporated in an ethical guidelines toolkit that will be developed and disseminated as part of this project. Work also continued on a second documentary film about child welfare reform, ethics, and the mental well-being of Indigenous foster children. In addition, planning got underway on an interactive website for the project.

Mental Health and the Law Advisory Committee

"People living with mental health problems and illnesses and their families must be accorded the same respect, rights, and entitlements, and have the same opportunities, as people dealing with physical illnesses such as cancer, diabetes, AIDS, and, indeed, as the general population."

Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada



The Saskatchewan Police Commission and other local police leaders are setting an example with ground-breaking policy changes to protect the privacy of those living with mental illness.

A provincial policy was adopted which recognized "orders or other records relating to The Mental Health Services Act or The Youth Drug Detoxification and Stabilization Act will not be disclosed" during a criminal occurrence security check. All police in Saskatchewan, including the Saskatchewan Provincial Police (RCMP), adhere to the policy. The policy makes a significant difference with regard to protecting the privacy of those with mental illness.

(L to R) Clive Weighill, Chief of Police, Saskatoon Police Service; Warren Koch, a person with lived experience who assists with the education of police on matters related to mental health at the Saskatchewan Police College; and Terry Coleman, Moose Jaw city councillor, former Chief of Police, Moose Jaw Police Service, and member of the MHCC's Mental Health and the Law Advisory Committee

Photo: Jill Lanigan

The Mental Health and the Law Advisory Committee (MHLAC) is addressing a wide range of issues, including:

- how legislation, policy, and services can be improved to enhance equality and social inclusion for people living with a mental health problem or illness;
- how protection of public safety can be balanced with the need to provide appropriate care and treatment for some of society's most vulnerable members;
- how changes to the current criminal justice system could help reduce the number of mentally ill people within it, as well as provide mentally ill people with improved access to hospital care before their actions lead them to enter the criminal justice system; and
- the kind of education and support police officers require to help them manage their interactions with people living with a severe mental illness.

Police Project: As part of this project, a report on a survey of mental health content in Canadian police in-service training programs was completed in 2010. The report included recommendations on the development of a model for continuing police education in this area. In addition, a study of interactions between police and those living with a mental illness was also completed and presented in March 2011 at the Pacific Forensic Psychiatry Conference in Vancouver. The study was led by B.C. Mental Health and Addiction Services and conducted in partnership with Simon Fraser University, the University of British Columbia, and the Canadian Mental Health Association—British Columbia Division. This project is now completed and it is hoped that the results of the two reports will influence police learning and education across the country. Knowledge exchange and activities related to these two reports got under way in 2011.

Together we can enhance equality and social inclusion for people living with mental health problems and illnesses

Members of the MHCC's Mental Health and the Law Advisory Committee

Some Advisory Committee members may be missing from the photo.

Human Rights Evaluation: The MHLAC is partnering with the Canadian Mental Health Association—Winnipeg Region and the Public Interest Law Centre of Legal Aid Manitoba to develop an instrument to evaluate the extent to which human rights are addressed in legislation, policies, and services for people living with mental illness. The instrument is currently being piloted in British Columbia, Manitoba, and Nova Scotia and is expected to be completed by September 2011. In early 2011, the project's consumer advisory group also completed the development of a mixed-media "Photovoice" presentation describing their experiences and perspectives on human rights and mental illness. It was first presented at a Mood Disorders Society conference in Winnipeg in March.

Trajectory Project: The MHLAC is funding a study in British Columbia, Ontario, and Quebec examining the trajectories (paths taken through the health and criminal justice systems) of individuals declared not criminally responsible due to a mental disorder (NCRMD). Areas of focus include duration of stay in a facility, treatment received, and how individuals responded. The study will help to inform stakeholders about clinical, organizational, or legislative changes, related to NCRMD groups, needed in the system. Quantitative data collection was completed in Quebec over the past year and data collection in Ontario and British Columbia is expected to be complete by August 2011. Members of the project committee also published a paper in 2010 on the issue of being "not criminally responsible" in the *Canadian Journal of Community Mental Health.* The project is expected to be completed by August 2012.

Additional work: Over the past year, additional work by the MHLAC has included input on Corrections Canada's development of a mental health strategy for use within the corrections system. Members of the MHLAC spent time on a working committee to help develop common language and procedures for inclusion in the strategy. In addition, the MHLAC continued to recommend that other police forces in the country adopt a policy not to disclose civil apprehensions under Mental Health Acts to third parties. This position was first adopted by the MHCC Board of Directors in May 2008. The Province of Saskatchewan is the only province so far to have adopted such a policy.

Together we can enhance equality and social inclusion for people living with mental health problems and illnesses

Calgary Chief of Police Rick Hanson was the keynote speaker at the MHCC's Annual General Meeting in Toronto in June 2010. Hanson shared thoughts about the police and justice systems and mental health issues.

(L to R) Louise Bradley, MHCC President and CEO; Rick Hanson, Calgary Chief of Police; and Michael Kirby, MHCC Chair

One of the projects of the MHCC's Mental Health and the Law Advisory Committee is a study of interactions between police and those living with mental health problems. The results of this study will influence police training and education across Canada.

(L to R) Clive Weighill, Chief of Police, Saskatoon Police Service; Warren Koch, a person with lived experience who assists with the education of police on matters related to mental health at the Saskatchewan Police College; and Terry Coleman, Moose Jaw city councillor, former Chief of Police, Moose Jaw Police Service, and member of the MHCC's Mental Health and the Law Advisory Committee

(L to R) Clive Weighill, Chief of Police, Saskatoon Police Service; and Terry Coleman, Moose Jaw city councillor, former Chief of Police, Moose Jaw Police Service, and member of the MHCC's Mental Health and the Law Advisory Committee

Science Advisory Committee

"Research that draws upon multiple sources of knowledge—such as science, clinical practice, the personal experience of people living with mental health problems and illnesses, and their families, the lessons learned from previous attempts at reforming policy and service delivery, and knowledge embedded in diverse cultural traditions—has helped to generate successful treatment and prevention approaches, as well as improved policies, practices, and mental health promotion activities."

Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada

Partly funded by MHCC, the Multicultural Mental Health Resource Centre (MMHRC) is a website developed in a partnership between the Commission's Science Advisory Committee and McGill University. The project, entitled "Ensuring Equity by Respecting Difference: Development and Evaluation of Resources for Multicultural Mental Health," aims to improve the quality and availability of appropriate mental health services for people from diverse cultural and ethnic backgrounds, including immigrants, refugees, and members of established ethno-cultural communities. Check out the new website, with enhanced resources for patients, families, community organizations, professionals and health planners, at www.mmhrc.ca.

(L to R) Abdel Hamid Afana, PhD, Institute of Community and Family Psychiatry, McGill University; Jaswant Guzder, MD, Associate Professor of the Department of Psychiatry, McGill University; John Docherty, Program Coordinator, Intervention Network for Persons Affected by Organized Violence; Sadeqa Siddiqui, Project Coordinator, South Asian Women Centre.

Photo: Paul-André Laroque

The Science Advisory Committee (SAC) provides advice on matters relevant to science and to Commission staff as required.

Consumer/Peer Research Network: The aim of this project is to foster the development of a network that will build opportunities for people living with mental health problems and illnesses to engage in research activities and to facilitate connections with other community and/or academic researchers interested in being involved in consumer/peer mental health and substance use research.

The project team completed its work in March 2011 and provided the SAC with a final project report and products, including:

- two reviews of research and published literature from Canada and abroad—*the On-line Summary of Consumer/Peer Mental Health Research in Canada: An Emerging Story* and the *International Consumer/Peer Research Summative Paper;*
- an applied research study, *Emerging Themes of Consumer Peer Research in Canada,* which involved 16 in-depth individual interviews with experienced consumer/peer researchers; and
- terms of reference for the network.

The basic structure of a website for the network was developed over the past year for the Commission's Knowledge Exchange Centre (KEC) web space. When it becomes public, the website will include space for documents, a calendar, research opportunities, a registry of members, and a forum. Over the past year, the project team also explored with the KEC potential resources to support further network and website development.

Multicultural Mental Health: This project focuses on ethno-culturally diverse groups, as well as service providers and policy-makers in Canada. Its goals are to:

- evaluate the impact of the resources used in the current system in mental healthcare for ethnically and culturally diverse populations; and
- develop and evaluate specific resources to address issues of cultural diversity in mental healthcare in Canada that are widely applied and used by people living with mental health problems and illnesses, and by practitioners, policy-makers and community organizations.

The Multicultural Mental Health Resource Centre (MMHRC) website—www.mmhrc.ca—is the working website for the project. The aim of the MMHRC is to improve the quality and availability of appropriate mental health services for people from diverse cultural and ethnic backgrounds, including immigrants, refugees, and members of established ethno-cultural communities. The website, which presents resources designed for patients, families, community organizations, professionals, and health planners, is well used and, during 2010–11, the MMHRC continued to add resources that will support an improved quality of service.

Together we can use research to increase knowledge and raise awareness

Members of the MHCC Science Advisory Committee

Seniors Advisory Committee

"The goal for older adults at every stage of the aging process is to ensure that they attain the best possible quality of life, are treated with dignity and respect, and receive the best possible treatment for mental health problems and illnesses that may emerge as they pass through important transitions associated with aging—such as retirement, alterations in income level, physical decline, and changing social support networks, including spousal bereavement and increased social isolation."

Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada

The MHCC's Seniors Advisory Committee has been developing new and updated *Guidelines for Mental Health Services for Seniors,* a reference tool for Canadian clinicians, planners and organizations whose mandate is to provide excellent care to seniors with mental health problems and support for their families. Long term care homes, such as the Beverly Center in Calgary, Alberta are an important component in the range of services that need to be available to seniors, along with other community and hospital-based services.

(L to R) Sharon Moore, RN, M.Ed., PhD, Member of the Seniors Advisory Committee and Associate Professor, Centre for Nursing and Health Studies, Athabasca University, Alberta; Rose Murray, Resident, Beverly Centre, Calgary; and Sue Hall, Pastoral Care Nurse, Beverly Centre, Calgary.

Photo: Dave Walker

The mission of the Seniors Advisory Committee is to ensure that the mental health of seniors is addressed through the inclusion of a lifespan perspective across all the work of the Commission, and that there is a focus on seniors' mental health issues in the Commission's initiatives.

The committee is now working on projects to help ensure older adults with mental health problems or illnesses will receive higher quality services and that the stigma of mental illness will be reduced for seniors, their family members and informal caregivers, healthcare professionals and providers, organizations, institutions, and policy-makers.

Guidelines Project: This project is focusing on older adults living with mental health problems and illnesses, and provides useful information for health service planners and providers. The 1988 document *Guidelines for Comprehensive Services to Elderly Persons with Psychiatric Disorders* has been, for over 20 years, a major reference document for mental healthcare planners and advocacy groups. This project is developing up-to-date, evidence-informed, and principle-based guidelines and service benchmarks for the planning of comprehensive mental health services for older adults in Canada. The draft of the new guidelines was completed in early 2011, and it is expected the new guidelines will be released in the latter part of the year.

The updated guidelines have been developed in three steps:

1. A current literature review of services for older adults with a specific focus on existing benchmarks in Canada and internationally.
2. A survey of Canadian mental health services for older adults, using identified benchmarks.
3. A consultation process on the draft guidelines document, integrating the findings of the survey mentioned above, and input from various stakeholder groups. This was to ensure that the perspectives of Canadian seniors themselves, and of family members, and healthcare professionals, were included.

The updated guidelines will most directly target geriatric mental healthcare providers and planners. However, the ultimate objective of the guidelines is to help ensure that older Canadians living with mental health problems and illnesses are receiving optimal and comprehensive services and supports. The guidelines will also support the Commission's development of the mental health strategy for Canada by providing a comprehensive model for a transformed mental health system for seniors. The guidelines will demonstrate how key concepts in the strategy—for example, recovery, health promotion, and prevention—can be addressed in seniors' mental health service delivery.

In 2011, the project committee also began working with the MHCC's Knowledge Exchange Centre and Communication department to develop an interactive on-line version of the guidelines and an on-line community of practice.

Anti-Stigma: This project, which got under way in late 2010, will identify and develop tools to address stigma experienced by older adults living with a mental health problem or illness when seeking services. The Canadian Coalition for Seniors' Mental Health is partnering with the MHCC on the project. Project planning, a literature review, and an environmental scan are in progress.

Together we improve the quality of life of older adults

Members of the MHCC Seniors Advisory Committee

Some Advisory Committee members may be missing from the photo.

Service Systems Advisory Committee

"In the broadest sense, the mental health system should encompass all those activities that help ensure that everyone living in Canada has the opportunity to achieve the best mental health possible and that they are able to take advantage of that opportunity."

Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada

Loïse Forest is a Montréal-based mental health peer support worker and is a consultant on recovery and mental health rights across Quebec. As a member of the MHCC's Service Systems Advisory Committee, Forest was one of the people who led the development and promotion of *Making the Case for Peer Support.* The report informs provincial policy makers, funders, and other stakeholders of the value of mental health peer support and provides guidance on ways to strengthen peer support in each province.

The Service Systems Advisory Committee (SSAC) advises the Commission on the elements required for a high-performing mental health system. Those ingredients include diversity, peer support/consumer-operated programs, supportive housing, human resources planning in the health area, concurrent disorder capacity, and the interface between primary healthcare and mental health systems across the country. The SSAC's work encompasses areas of federal jurisdiction, as well as provincial systems.

Diversity: This project, which targets ethno-culturally diverse groups, immigrants, refugees, and marginalized populations, aims to promote promising practices for inclusion in the mental health strategy for Canada, and to develop consensus on strategies that provinces and regional mental health systems may consider in meeting the needs of an increasingly diverse population. In 2009, the SSAC published a report titled *Improving Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Groups: Issues and Options for Service Improvement.* The report is available in the SSAC section of the Commission's website at www.mentalhealthcommission.ca.

A steering committee was formed to implement a knowledge translation and exchange plan, funded through a $10,000 grant from the Alberta Heritage Foundation for Medical Research. The steering committee developed and delivered a workshop for health decision makers in Alberta in May 2010 to look at barriers to, and opportunities for, implementing strategies outlined in the report. Knowledge exchange is continuing in 2011. Plans include webinars and other activities designed to disseminate the report more widely.

Peer Support: In September 2010, the SSAC published a report titled *Making the Case for Peer Support,* providing a high-level description of peer support in Canada and other countries. The project team found that peer support is beneficial to people and can even save lives by increasing personal resourcefulness, self-belief, and hope. The report also shows that peer support is in its infancy—full of promise, but under recognized and under-resourced. The report is available on the SSAC section of the Commission's website at www.mentalhealthcommission.ca.

The report was developed by the SSAC through a project committee made up of consumers of mental health services, service providers, and Commission staff. In addition to a review of Canadian and international research on peer support, the project consulted directly with people involved with peer support across the country and government decision makers. The research team was an international group of peer leaders. The project research team received more than 200 written responses and met with over 600 people in focus groups and interviews across Canada. The respondents included people with lived experience, family members, service providers, policy-makers, and others who shared their stories and hopes for peer support.

Knowledge exchange activities in 2010–11 included the development of French and English summary documents of the report and PowerPoint presentations about *Making the Case for Peer Support.* English- and French-language webinars took place in early 2011.

Work is continuing on following the recommendations outlined in the report. Some of them have already informed a related Commission project called the *Peer Support Project.*

Strategy to Develop Housing and Related Supports: The SSAC undertook this project to inform the Commission on the current housing supports needed for people who live with a mental health problem or a mental illness in Canada.

Research for this project was completed in spring 2010. The project committee carried out relevant literature reviews and an environmental

scan of housing and related supports for people living with mental health problems and illnesses across Canada. This scan identified and described housing and community support resources, new housing supply, government commitments to new housing starts, key stakeholder consultations, and proposed standards and benchmarks.

The research included five on-line questionnaires aimed at understanding the current housing and related support needs for people living with mental illness and addictions. Each questionnaire targeted different stakeholders: (1) people living with mental health problems or mental illness; (2) family members of people living with mental health problems or mental illness; (3) hospital administrators and/or clinical leads; (4) housing providers; and (5) community-based mental health service providers.

The project committee was expecting to finalize its report by June 2011 with recommendations on how to improve housing and supports across Canada. A process has also been put in place for regular knowledge exchange meetings with the reference groups that the project team has established across the country. The first meeting was scheduled for May 2011. A $25,000 Knowledge Translation grant has also been received from the Canadian Institutes of Health Research to support knowledge exchange activities.

Together we can create a strong mental health system for Canadians

Members of the MHCC Service Systems Advisory Committee

Some Advisory Committee members may be missing from the photo.

Workforce Advisory Committee

"There is also much that can be done to promote mental health in the workplace. In addition to improving overall mental health and well-being, such efforts can also help to improve the productivity of the workforce and reduce the growing costs of insurance claims for both physical and mental health conditions."

Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada

Thousands of Calgarians use the C-Train public transit system to get to and from work each day. Members of the Project Review Committee developing a National Standard of Canada for Psychological Health and Safety in the Workplace make their way to the Mental Health Commission of Canada's office. The voluntary standard, a first of its kind in the world, is anticipated to be published in 2012.

(L to R) Mary Ann Baynton, Mary Ann Baynton and Associates Consulting; Roger Bertrand, Group for Prevention and Promotion Strategies (GP^2S); Jim Ferrero and Daniel Langlais, Bureau de normalisation du Québec (BNQ); Annette Thrasher, Human Resources and Skills Development Canada (HRSDC); and Jeanne Bank, Canadian Standards Association (CSA)

Together we can create psychologically safe and healthy work environments

The Commission's Workforce Advisory Committee (WFAC) is developing methods to provide workforce leaders—and workplaces and workforces in general—with the tools they need to change the way mental health is addressed at work. These tools are intended to make work environments more capable of dealing with mental health and psychological safety in a manner that leads to enhanced workforce health and continual improvement of the work environment.

Report on Mental Health in the Workplace: In May 2010, workplace mental health expert Martin Shain completed his second report, this one titled *Tracking the Perfect Legal Storm,* asserting that, in effect, a "legal storm" is brewing with respect to mental health protection at work and that employers have an emerging responsibility to provide a psychologically safe workplace. The Commission officially released the report in September 2010 in Vancouver at a meeting with employers, union leaders, and workplace health and safety and legal experts. At the meeting, which was co-sponsored by the MHCC and Great-West Life, delegates discussed the strategies, tools, and support needed for employers to provide a psychologically safe workplace in response to Dr. Shain's report.

A National Standard of Canada for Psychological Health and Safety in the Workplace: Arising out of the Shain report, the Commission spent part of the year working on a plan to move forward with the development of a National Standard of Canada for Psychological Health and Safety in the Workplace. Funding for the creation of the standard is being provided by the Government of Canada—specifically, Human Resources and Skills Development Canada, the Public Health Agency of Canada, and Health

Members of the MHCC Workforce Advisory Committee

Some Advisory Committee members may be missing from the photo.

Lieutenant Colonel Stéphane Grenier makes a presentation on the MHCC's *Peer Support Project,* which aims to enhance the utilization of peer support through the creation and application of national standards of practice.

Canada—as well as Bell Canada. The Commission is working with the Bureau de normalisation du Québec and the Canadian Standards Association on this project. The new standard will be standalone and voluntary and will serve as a resource for employers for assessing, creating, and sustaining a psychologically safe and healthy work environment. It is anticipated that the new standard will be published in late summer 2012.

Executive Leadership and Policy: This WAC project is focusing on senior organizational leaders in Canada. A set of CEO Leadership Guidelines was published in 2010 to encourage CEOs and other senior leaders to make a decisive commitment to mental health in the workplace. The guidelines are an initial tool to get organizations started on improving mental health in the workplace so that employees living with mental health problems/illnesses in the workplace will have a better work environment that also lessens mental health risks and improves psychological safety for all employees. For more information, please visit the Leadership website at www.mhccleadership.ca.

Sustainable Income and Employment: The Aspiring Workforce: This project is aimed at people living with mental health problems and illnesses who have never worked, who have not been in the workforce for a prolonged period of time, or who suffer from episodic mental health problems or illnesses and for whom disability coverage is inadequate. The project committee has been reviewing "promising practice" in existing Canadian employment initiatives (e.g. supported employment, peer-run/alternative businesses, corporate sector, etc.); and developing a "legislative model" for disability benefits. The committee completed a mid-point progress report in November 2010. In March 2011, the committee met with policy-makers from across the country to discuss the issue and how to shape the project's findings in ways that will be most useful to policy-makers. The committee expects to complete its work by fall 2011.

Improved Mental Healthcare: This project is designed to provide Canadian employees and employers with better information about successful workplace programs that have been shown to improve mental health in the workplace. An employer's guide to improving mental health in the workplace is scheduled to be completed by mid-2011.

Peer Support Project: The use of peer support is founded on the belief that people who have faced, endured, and overcome the adversity of mental health conditions can offer beneficial support, encouragement, and hope to others facing similar situations and thereby speed their recovery. Through our *Peer Support Project,* the Commission is aiming to validate the establishment of peer support as an integral part of the continuum of services offered to individuals with mental health problems and illnesses, as well as increase the availability of peer support services within workplaces.

In 2010, the *Peer Support Project* team undertook a comprehensive national consultation process in which nearly 300 peer support workers from over 100 cities across Canada expressed interest in helping to shape the project as it moves forward. The team then developed a *Peer Support Framework,* which includes Standards of Practice, comprised of a code of conduct, competencies, and knowledge and experience requirements for national certification of peer support workers, and criteria to help determine an organization's readiness to properly implement and manage peer support services.

The priority for the next phase of the *Peer Support Project* is to partner with organizations that can integrate peer support and undergo evaluation to develop evidence about what approaches work best in what types of work settings.

Concurrently, the project will focus on validating, with existing peer support service providers, the certification process for peer support workers.

The research and evaluation component of the project is being supported by the Centers for Disease Control and Prevention in the United States, the University of Ottawa, Queen's University, and the Centre for Addiction and Mental Health in Toronto.

Leading the way

The Mental Health Commission of Canada has recruited some of Canada's most experienced, informed, and compassionate mental health experts, including people with lived experience of mental illness, to serve on its Board of Directors, eight advisory committees, Executive Leadership Team, and staff.

As a team, they are working with a wide range of stakeholders across the country to develop a comprehensive mental health strategy for Canada, combat stigma, generate knowledge, turn that knowledge into action, and change policy in order to transform the mental health system and transform the lives of people living with mental health problems and illnesses.

The MHCC's Board of Directors guide, support, and encourage the Commission's mandate. The non-government directors and government-appointed directors come from every province and territory in Canada, representing the country's vast mental health stakeholder community.

(L to R) Manitok Thompson; Dana Heide; Chris Summerville; Kevin McNamara; Louise De Bellefeuille; Michael Kirby; Patrick Dion; Madeleine Dion Stout; David S. Goldbloom, MD; Andy Cox; Lorraine Breault; Fern Stockdale-Winder; Dan Florizone; Jeannette LeBlanc; and Joan Edwards-Karmazyn

Missing from the photo: J. Michael Grass, James Morrissey, Morris Rosenberg, Mary May Simon, Milton Sussman, and Glenda Yeates

Photo: Brian Dupuis

Directors

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Government of Nova Scotia

James Morrissey
Ernst & Young LLP, Ontario

Morris Rosenberg
Health Canada, Ontario

Mary May Simon
Inuit Tapiriit Kanatami, Quebec (Nunavik)

Fern Stockdale Winder, PhD, MHCC Vice Chair
Saskatoon City Hospital, Saskatchewan

Chris Summerville
Manitoba Schizophrenia Society Inc., Manitoba

Manitok Thompson
Harvest Moon Acoustics, Alberta and Nunavut

Milton Sussman
Government of Manitoba

Glenda Yeates
Health Canada, Ontario

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

Advisory Committee Chairs

Child and Youth
Simon Davidson, MD
Children's Hospital of Eastern Ontario (CHEO)

Family Caregivers
Ella Amir
AMI–Quebec, Quebec

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

Gaye Hanson
Hanson and Associates, Yukon (interim)

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

Science
Elliott Goldner, MD
Simon Fraser University, British Columbia

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

Service Systems
Steve Lurie
Canadian Mental Health Association, Ontario

Workforce
Ian Arnold, MD
Health, safety and environmental management consultant, Ontario

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

Executive Leadership Team

Louise Bradley, MS, RN, CHE
President and CEO

Jayne Barker, PhD
Vice President, Research Initiatives and Mental Health Strategy

Geoff Couldrey
Vice President, Knowledge and Innovation

Michelle McLean, LLB
Vice President, Public Affairs

Jeff Moat
Vice President, Partners for Mental Health

Nathalie Pichette, CA
Chief Financial Officer

John Stokdijk, CMA
CFAO

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

Together we lead the transformation of the mental health system

MHCC Advisory Committee chairs along with MHCC leads

(L to R) **Steve Lurie,** Service Systems Advisory Committee; **Gaye Hanson,** First Nations, Inuit and Métis Advisory Committee; **Marie-France Tourigny-Rivard,** Seniors Advisory Committee; **Ted Ormston,** Mental Health and the Law Advisory Committee; **Jayne Barker,** Vice President, Research Initiatives and Mental Health Strategy; **Simon Davidson,** Child and Youth Advisory Committee; **Ian Arnold,** Workforce Advisory Committee; **Ella Amir,** Family Caregivers Advisory Committee; **Janice Popp,** Director, Policy and Research and Mental Health Strategy; **Elliot Goldner** (absent), Science Advisory Committee

Some Advisory Committee members may be missing from the photo.

The Executive Leadership Team

(L to R) **Jayne Barker,** Vice President, Research Initiatives and Mental Health Strategy; **Jeff Moat,** Vice President, *Partners for Mental Health;* **Louise Bradley,** President and CEO; **Geoff Couldrey,** Vice President, Knowledge and Innovation; **Nathalie Pichette,** Chief Financial Officer; **Michelle McLean,** Vice President, Public Affairs

Some Advisory Committee members may be missing from the photo.

As part of its *Live Right Now* campaign to promote physical and mental health, CBC Radio's "The Current" aired two programs that focused on mental health in January 2010. Award-winning musician Steven Page, the former lead singer of the Barenaked Ladies who has a history of depression, was the guest host.

(L to R) **David S. Goldbloom,** MD, MHCC Vice-Chair; **Steven Page,** musician; **Anna Maria Tremonti,** CBC radio host and journalist

Members of the MHCC Board of Directors meet at the 2010 Annual General Meeting in Toronto

(L to R) **Simon Davidson,** MD, Chair of the MHCC's Child and Youth Mental Health Advisory Committee, **Andy Cox,** Board member, with his spouse, **Wanda Cox**

Financial Statements of the

MENTAL HEALTH COMMISSION OF CANADA

Year ended March 31, 2011

The financial statements represent an essential element of the Mental Health Commission of Canada's overall picture. MHCC's 2010/2011 statement of financial position has been independently audited by KPMG.

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, 2011, 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, 2011, and its results of operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

Chartered Accountants

KPMG LLP

June 14, 2011

Calgary, Canada

Statement of Financial Position

March 31, 2011, with comparative figures for 2010

	2011	2010
Assets		
Current assets		
Cash and cash equivalents	$ 6,685,337	$ 4,548,749
Contract advances	2,881,345	1,702,611
Accounts receivable	654,120	979,886
Deposits and prepaid expenses	149,526	201,093
Inventory	52,985	–
Investments (note 3)	43,463,346	41,471,051
	53,886,659	48,903,390
Long term investments (note 3)	18,884,861	48,583,898
Capital assets (note 4)	1,711,705	726,421
	$ 74,483,225	$ 98,213,709
Liabilities and Net Assets		
Current liabilities		
Accounts payable and accrued liabilities	$ 6,589,996	$ 3,012,219
Deferred program fees (note 2b)	28,024	12,221
Deferred contributions – operating (note 5)	36,558,756	32,996,086
	43,176,776	36,020,526
Deferred capital contributions (note 6)	1,711,705	726,421
Deferred contributions – operating (note 5)	29,479,012	61,403,145
Net assets	115,732	63,617
Commitments (note 7)		
	$ 74,483,225	$ 98,213,709

See accompanying notes to financial statements

On behalf of the Board:

Patrick Dion

Michael Kirby

Statement of Operations and Changes in Net Assets

Year ended March 31, 2011, with comparative figures for 2010

	2011	2010
Revenues:		
Grant income (note 5)	$ 42,755,781	$ 28,232,329
Mental health first aid income	792,855	–
Interest and other income	67,465	41,868
	43,616,101	28,274,197
Expenses:		
Direct client services (note 9)	24,575,370	11,491,768
Salaries and benefits	7,967,485	5,565,440
Services	6,193,042	7,441,038
Travel	2,411,421	1,797,912
Rent	673,791	301,346
Meetings and events	595,834	820,598
Materials	754,347	512,879
Amortization	392,696	301,348
	43,563,986	28,232,329
Excess of revenues over expenses	52,115	41,868
Net assets, beginning of year	63,617	21,749
Net assets, end of year	$ 115,732	$ 63,617

See accompanying notes to financial statements.

Statements of Cash Flows

Year ended March 31, 2011 with comparative figures for 2010

	2011	2010
Cash provided by (used in):		
Operations:		
Excess of revenues over expenses	$ 52,115	$ 41,868
Items not affecting cash flows:		
Amortization of deferred capital contributions (note 6)	(392,696)	(301,348)
Amortization	392,696	301,348
	52,115	41,868
Net change in non-cash working capital balances:		
Contract advances	(1,178,734)	(1,702,611)
Accounts receivable	325,765	(890,095)
Deposits and prepaid expenses	51,567	(145,691)
Inventory	(52,985)	–
Accounts payable and accrued liabilities	3,577,777	1,832,265
Deferred program fees	15,803	12,221
	2,791,308	(852,043)
Investing:		
(Purchase) redemption of investments	27,706,742	(90,054,949)
Purchase of capital assets	(1,377,980)	(212,883)
Deferred capital contributions	1,377,980	212,883
	27,706,742	(90,054,949)
Financing:		
Deferred contributions	(28,361,462)	91,451,895
Net increase in cash and cash equivalents during the year	2,136,588	544,903
Cash and cash equivalents, beginning of year	4,548,749	4,003,846
Cash and cash equivalents, end of year	$ 6,685,337	$ 4,548,749
Supplemental cash flow information:		
Interest received	$ 41,401	$ 36,802

See accompanying notes to financial statements.

Notes to the Financial Statements

Year ended March 31, 2011

1. Description of the business:

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

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

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

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

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

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

The Commission is funded through 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, 2011.

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) 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

e) Financial instruments:

All financial instruments are initially recognized at fair value on the statement of financial position. The Commission has classified each financial instrument into the following categories: held-for-trading financial assets and liabilities, loans and receivables, held-to- maturity investments, available-for-sale financial assets, and other financial liabilities. Subsequent measurement of the financial instruments is based on their classification.

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

Financial instruments of the Commission consist of cash and cash equivalents, accounts receivable, investments and accounts payable and accrued liabilities. Except where otherwise disclosed, as at March 31, 2011, 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.

f) 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.

g) Inventories:

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

h) 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.

i) Future accounting pronouncements:

Prior to April 1, 2012 the Commission will need to select one of the two following alternatives for financial reporting:

i) International Financial Reporting Standards ("IFRS"):

The Canadian Institute of Chartered Accountants will adopt IFRS as Canadian GAAP for publically accountable enterprises. It is optional for not-for-profit enterprises.

ii) Accounting Standards for Not-for-Profit Enterprises:

Canada's Accounting Standards Board (AcSB) released the financial standard regarding a new set of accounting standards for Not-for-profit Enterprises. The majority of the recognition and measurement standards in the existing CICA Handbook that are relevant to Canada's not-for-profit organizations are retained with few modifications.

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

3. Investments:

Investments consist of fixed income bonds issued by the Government of Canada, crown corporations and provincial governments maturing within two years. These investments have yields ranging from 1.02% to 2.13% (2010- 0.41% to 2.13%). The fair value of investments at March 31, 2011 is $60,661,072 (2010 – $89,071,203)

4. Capital assets:

			2011	2010
	Cost	Accumulated amortization	Net book value	Net book value
IT infrastructure	$ 192,868	$ 90,687	$ 102,181	$ 88,247
Software	202,762	189,448	13,314	13,316
Office equipment	217,717	68,930	148,787	70,198
Furniture	576,063	175,692	400,371	136,782
Leasehold improvements	1,603,118	556,066	1,047,052	417,878
	$ 2,792,528	$ 1,080,823	$ 1,711,705	$ 726,421

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:

	2011	2010
Balance, beginning of year	$ 94,399,231	$ 2,947,336
Grants received	15,535,000	119,716,548
Less amount recognized as revenue	(42,755,781)	(28,232,329)
Amounts related to deferred capital contributions	(985,284)	88,465
Other adjustments	(155,398)	(120,789)
Balance, end of year	66,037,768	94,399,231
Current portion	36,558,756	32,996,086
	$ 29,479,012	$ 61,403,145

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:

	2011	2010
Balance, beginning of year	$726,421 $	814,886
Capital contributions	1,377,980	212,883
Amounts amortized	(392,696)	(301,348)
Balance, end of year	$ 1,711,705	$ 726,421

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:

2012	$ 425,128
2013	426,999
2014	212,082
2015	184,249
2016	157,231
	$ 1,405,689

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:

2012	$ 26,578,112
2013	25,462,872
2014	107,760
	$ 52,148,744

As at March 31, 2011, the Commission is committed to an additional $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:

a) 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, $654,120 (2010 - $979,886) relates to accrued interest and other receivables. Included in accounts receivable is $7,886 which was incurred on behalf of a newly created charity that supports the mandate of the Commission and whose directors and officers include the Commission's chair and CEO. As at March 31, 2011, 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 (2010 - $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.

b) 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.

c) 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 $66,853 (2010 - $45,487) 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.

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Mental Health Commission of Canada

Commission de la santé mentale du Canada