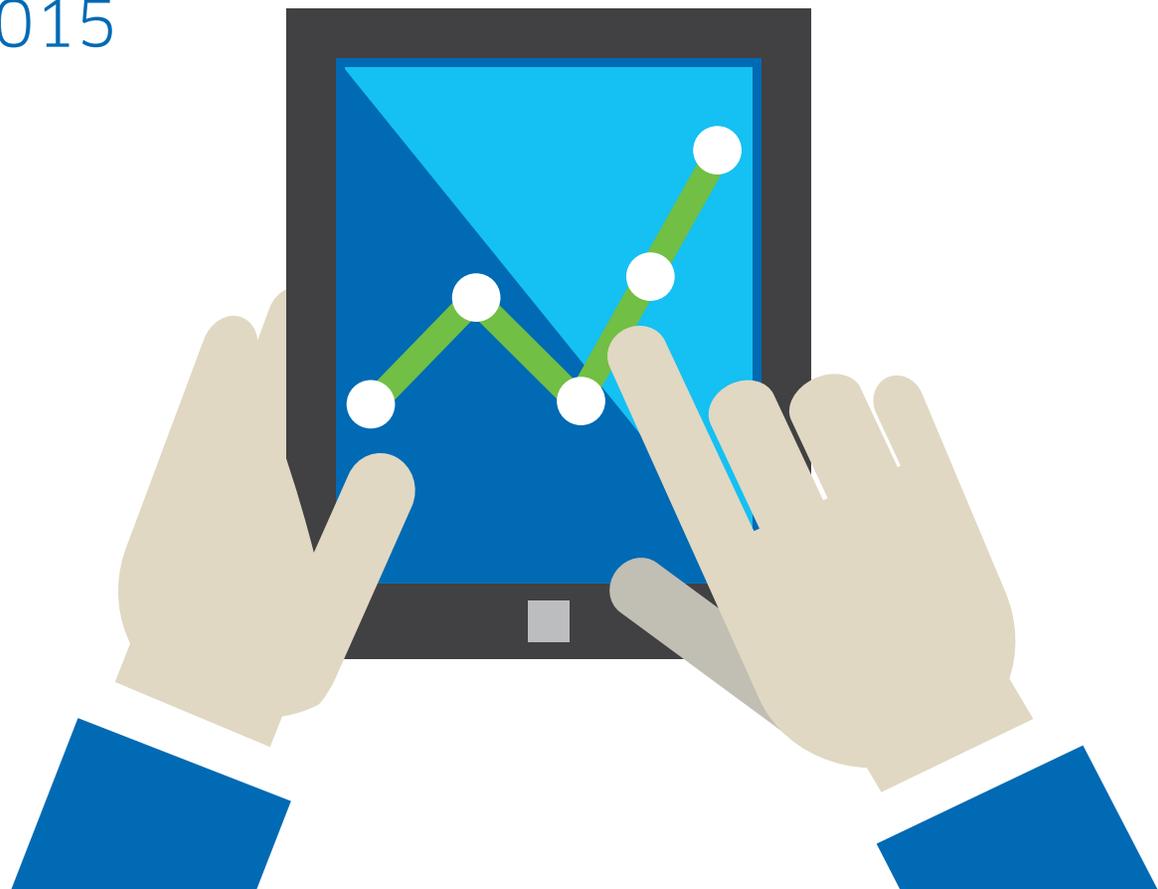Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada

Towards Creating a Mental Health Action Plan for Canada

Roundtable Report — 2015

Introduction

Established in 2007 with an initial 10-year mandate (2007-2017), the Mental Health Commission of Canada (MHCC) is an arm's length, non-profit organization funded by Health Canada. Among its initiatives, the MHCC's work includes creating the country's first mental health strategy, working to reduce stigma, advancing knowledge exchange in mental health, and examining how best to help people who are homeless and living with mental health problems and illnesses.

In 2012, the MHCC released *Changing Directions, Changing Lives: The Mental Health Strategy for Canada (Strategy)*. Drawing on the best available evidence in the mental health field, and on input from thousands of people from across Canada, the Strategy translates evidence into recommendations for action. The scope of the Strategy is broad and it is organized into six strategic directions. Each strategic direction focuses on one critical dimension of the mental health system in Canada, and together they combine to provide a comprehensive blueprint for change.

In order to identify priority areas in the six strategic directions from the Strategy (Appendix A), between January and May 2015, the MHCC conducted a series of consultations with key stakeholders in each province and territory, as well as specialized and population-specific panels, with the aim of developing a Mental Health Action Plan for Canada (Action Plan).

In building the Action Plan, these consultation sessions set out to:

1. Transform complex strategic directions and ideas into concrete actions for uptake, adoption, and implementation;

2. Leverage expertise and lived experiences to improve and enrich the Strategy; and,

3. Identify areas in which a broader, national approach to mental health could be improved over the next decade of the MHCC's renewed mandate (2017-2027).

The following report summarizes each of the consultations and offers an overview of emerging themes from these conversations. As the Strategy outlined, there is no homogenous approach that can be taken to improve the mental health system in Canada. People with lived experience and providers in different parts of the country

naturally have different needs. As such, this report aims to identify the commonalities and differences that appeared in conversations with providers, stakeholders, and people with lived experience in each of the provinces and territories. It also aims to assist the upcoming Citizens Reference Panel in its deliberations by providing a foundation for further discussion on local, provincial/territorial, and national priorities and challenges in advancing an Action Plan.

Each consultation was structured around five questions, and conducted by a facilitator who led the discussion. In most cases, participants conversed in small groups and then reported back to the room. Facilitators made every effort to ensure that each group represented diverse backgrounds, interests, and experiences in mental health and mental health provision.

The five questions used to structure discussion were as follows:

1 Which of the Mental Health Strategy's six strategic direction(s) does the work of your organization most advance? What should our organizational focus be in relation to Strategic Directions?

2 What actions are priorities for your organization? What does your organization see as its priorities? Can we find on what the overall priorities might be?

3 Is the needle moving when it comes to mental health? What is working, what is not? What are the most pressing issues and barriers?

3 What do you want national efforts to focus on in terms of system level change? What issues? What actions?

3 Can we prioritize the most critical priorities at a national level?

The ensuing discussions varied somewhat in their structure and in their fidelity to these questions, but the same basic themes and issues remained. The summaries contained in this report have been written with a view to capturing and articulating the broad themes and notable recommendations that emerged from each consultation. Those who took part in these sessions are referred to in the following report as 'participants'.

Contents

Executive Summary

Despite substantial progress in recent years, the provision of mental health services in Canada remains insufficiently resourced and do not meet the growing needs of the population. Partly as a consequence of successful anti-stigma campaigns such as Bell Let's Talk, mental health problems and illnesses are emerging as major points of discussion in offices, boardrooms, living rooms, and at kitchen tables across the country.

Though attitudes have changed and evolved with tremendous speed, institutional mechanisms have yet to catch up. Among developed countries, Canada spends the least in treating mental health as a proportion of its GDP. As a result, many providers find themselves unable to meet needs and insufficiently resourced to adequately address the issues they face.

Our country's unique and expansive geography, its diverse array of remote and hard to reach populations, its complex demography, and its deep cultural pluralism all pose significant challenges for any concerted effort on a national scale. Yet, as the various consultations convened by the Mental Health Commission of Canada (MHCC) in the first part of 2015 clearly reveal, that is exactly what is needed.

The following paragraphs bring together the key findings and points of agreement from these sessions.

PROGRESS MADE, CHALLENGES REMAIN

One theme of many consultations was a general expression of optimism about the progress that has been made on mental health in recent years. For the first time, many participants agreed, it is possible to have serious and policy-focused conversations in the public sphere and the potential to substantively engage with key stakeholders and decision-makers is greater than ever. Nonetheless, the partial mainstreaming of mental health presents certain challenges.

As something that touches upon so many other issues, mental health is often at risk of being subsumed or absorbed – both institutionally and conceptually. Mental health, after all, is not just a matter for individual people but rather a broad social, political, and economic issue. For one, mental

> Bringing together a vast pool of experience from every corner of the country, participants repeatedly and consistently emphasized Canada's unique challenges. They stressed that improving mental health care required a holistic and systemic approach, including increased funding and resources.

illness costs the economy. More than that, it is tied to innumerable socioeconomic factors such as poverty and income inequality. It is therefore manifested quite systemically in much the same way as physical health. For this reason, as participants overwhelmingly agreed, any national approach needs to take into consideration the social determinants of mental health (its "root causes") and and address, holistically, the problems we face.

Participants in several different panels were quick to note that the current funding shortfall severely constrains the capacity of organizations dealing with mental health to do anything more than crisis management. As a result, the structural issues associated with it often go chronically unaddressed. Quite a few participants felt that more resources would allow for early intervention and more effective work with children would go a long way towards addressing some of these structural issues. Several also noted that their organizations often do not have contact with individuals until their conditions become acute – again, frequently because of a lack of resources.

Many expressed feelings that mental health still enjoys second-tier status, despite the gains made in combatting stigma. This observation is corroborated by the disparity in how physical health is treated when compared to mental health.

Though Canada's public healthcare system offers treatment and diagnosis, free at the point of use, when it comes to physical health, the same cannot be said for mental health. Many vital services such as psychological counseling are often unavailable to people who need them because private providers are too expensive.

Funding issues aside, participants repeatedly expressed concern about how existing resources should be distributed and information shared. There was widespread agreement around the need for better data collection and pooling of research. This, among other things, was frequently cited as a means to combat institutional siloing and insularity between organizations dealing with mental health. The current system, as some noted, is something of a patchwork that lacks unified operational guidelines and collectively agreed upon best practices.

FIRST NATIONS, INUIT, AND MÉTIS PERSPECTIVES

While participants at the six separate territorial and indigenous consultations emphasized many of the same issues as those at other sessions, their outlooks were notably less optimistic and pervaded by a greater sense of urgency. Many felt that chronic lack of resources for mental health had an especially large impact in their communities, as evidenced by rates of suicide higher than the national average. Several also noted the geographic challenges associated with effectively delivering mental health services to culturally and linguistically diverse populations spread across large areas.

One result of these shortfalls, particularly in the North, is that correctional facilities are overcrowded with people living with mental health problems or illnesses who they are not equipped or trained to treat.

At several of the consultations, participants also argued for greater indigenous representation on decision-making bodies and relevant boards. One problem, as several noted, is that diverse indigenous groups are often approached monolithically and in a manner not sensitive to or cognizant of their culture or lived experience. Some key materials related to mental health are currently only available in English or in written formats that make them inaccessible to some individuals and communities that need them.

THE WAY FORWARD

One key takeaway from these consultations is that there is no easy solution to addressing our mental health challenges. Due to its structural nature, mental health is by definition an ongoing national concern relevant to everyone, from policymakers to office managers to emergency responders to frontline workers in health, policing, and education.

Only a holistic and cross-sectoral approach, which takes advantage of the competencies of individual organizations and sectors, can begin to tackle the challenges in Canada's mental health system.

To this end, participants at these consultations offered a series of important and specific suggestions drawing both on their lived experiences and expertise.

Also emphasized, both in the indigenous consultations and others, was the need to ensure compatibility between emerging conceptual ideas around of mental health and concepts like "mental wellness" which are more resonant with First Nations.

What follows below is a list of some of the most frequently recurring and widely shared objectives and prescriptions:

- The need for national guidelines and accreditation standards to ensure that organizations are making use of the most up to date information and that there are structures of accountability;
- Investment in mental health throughout the life period beginning in the early years so that identification of illnesses and problems happens sooner rather than later;
- Better support for at risk individuals at key life transition points, such as the transition from youth to adulthood;
- Integration of mental health into the school curriculum, particularly in postsecondary;
- Integration of mental health into the training of key frontline workers like emergency responders, police, border officials, and corrections officers;
- Use of alternative formats like video as a means to reach new audiences, particularly the young;
- Action on affordable and supportive housing that can function as a platform for the further delivery of mental health services;
- The conceptual and institutional integration of addictions, substance abuse, and mental health;
- Deeper awareness of issues associated with eating disorders and the possible integration of these into the MHCC's strategic framework;
- Improving methods of data collection and information sharing, possibly through the creation of a national database;
- Making further use of the MHCC as a means to continue fostering collaboration and building partnerships.

These suggestions, and many more, are further detailed in the summaries that follow. While the road to an effective national strategy for dealing with mental health is undoubtedly a long and winding one these consultations, and those still to come, are pointing the way forward.

The National Perspective

National Roundtable, Ottawa – March 19, 2015

The discussions were structured around the six strategic directions from the Mental Health Strategy for Canada. With the help of a facilitator, twenty-nine individuals representing a cross-section of the mental health sector took part in a series of lengthy and detailed discussions in small groups, reporting back to the room at large after each discussion.

In the opening session, many participants agreed that their various organizations touched on all six of the MHCC's strategic directions in the course of their work. This suggests, as several noted, a symbiotic relationship between them. One of the problems associated with this, as several observed, is that setting concrete priorities can be difficult as a result. Each organization has specific expertise, but without a broader plan or approach and agreed-upon objectives, such expertise will not be deployed efficiently. The fundamental challenge then, as participants agreed, is to formulate a plan that respects the individual competencies of organizations and providers while ensuring that they work in unison as part of a harmonious and truly nationwide strategy. With this in mind, it was agreed that any efforts on a pan-Canadian Action Plan will need to respect and be aware of regional differences and the unique social needs of patients and providers in different parts of the country.

Participants generally expressed optimism about the progress that has been made regarding broader public awareness of mental health issues thanks to initiatives like Bell Let's Talk, but concluded that systemic and cultural changes are still very much needed. In particular, several noted that stigma around mental health problems and illnesses has been somewhat reduced thanks to several successful campaigns, but much remains to be done. One potential risk of this progress is that it will encourage complacency and reduce further action at a time when it is needed the most.

There was broad agreement on the need for a holistic approach to mental health that looks beyond issues associated with care or treatment, and towards both prevention and awareness of the social determinants of health as well as areas of overlap with other spheres of public policy such income inequality. Participants concurred that mental health infrastructure in Canada still needs to grow and that only further research and funding can make this a reality. While a strategy is needed to

> Several participants expressed optimism about the ongoing discussion around strategies related to mental health and praised the MHCC's existing Mental Health Strategy for Canada. However, a few noted that the progress that has been made at the conceptual level has yet to translate into concrete, systemic change on the frontlines of mental health service delivery.

facilitate the implementation of new approaches, it simply cannot happen without funding, which continues to be inadequate in most areas.

There was also widespread agreement that the future availability of such resources will ultimately be a question of sustained political will, which goes beyond the exigencies of individual election cycles.

A recurrent theme appearing across quite a few of the discussions was the issue of silo reduction. Many felt that in spite of the presence of a national efforts, policymakers, researchers, providers, and governments continue to work within insular spaces making use of their own information and failing to collaborate on a holistic level.

A few other specific issues emerged. Importantly, participants noted that mental health provision in Canada remains essentially two-tiered in a manner not found anywhere else in the health system due to the inability of some to pay for psychological counseling.

One group of participants noted that issues associated with eating disorders were absent from the six strategic directions and argued they should be included.

The question also emerged as to whether the MHCC should function primarily as an enabler and facilitator or as a provider responsible for allocating funding and grants to other organizations. Many participants felt that both advocacy and funding should be left to others and that the MHCC should function primarily as a facilitator that aims to unite disparate voices and set priorities – engaging in a strategy of leading from behind and promoting best practices. Also discussed was the possibility of supplementing the six strategic directions with a report card and/or national standards for access to assist and incentivize their implementation, with the possibility of linking these to funding.

Several participants also emphasized educational and training issues. In particular, the need for national training standards for first responders and the need to better expose future mental health professionals to the realities of frontline work and the areas of greatest need across the field. One group recommended the implementation of a mental health education program in schools across the country as a means to raise awareness and continue to reduce stigma. A related education issue was the inadequate training of family doctors to treat mental illness.

Several noted that, in addition to the need to respect and accommodate regional differences, it is necessary to take a culturally sensitive and inclusive approach to the language used around mental health ("mental wellness" being a more relevant and resonant concept to many First Nations, for example).

The need for an approach that takes seriously the experiences and realities facing First Nations, Inuit, and Métis communities was a consistent theme during the discussion. In addition to issues of language, several participants noted that actual access to care remains sparse in many parts of the country, particularly in the North.

As part of the broader discussion related to disparities and differences between regions, many participants stressed the importance of continuing to advance knowledge about mental health specific to diverse populations so as to better address the needs of patients and avoid a heavy-handed or homogenous approach.

A major component of this, as several indicated, will be greater cooperation between all levels of government to ensure that available research and information is shared. Both improved intergovernmental and interministerial cooperation will be important moving forward.

One group of participants noted that the justice system and the mental health provision sector remain at odds, and that a wider dialogue incorporating stakeholders there could be an important next step. The need for integration on the frontlines between addiction and mental health programs was also mentioned during the discussion, as did the broader need to treat addiction as mental illness.

From West to East: Regional Dialogues

Vancouver, British Columbia – January 27th, 2015

Many of the broad themes that emerged in other consultations recurred throughout the Vancouver session. However, there was even stronger agreement among participants on the need for a holistic and systemic approach.

Participants concurred on the importance of considering the social determinants of health in all discussions of mental health and contextualizing it as something that cuts across all sectors. As one participant noted, jurisdictions that are broadly concerned with social justice and equality, and which consequently integrate mental health into a broader social agenda, usually results in better outcomes. Another noted, in support of the need for a holistic and cross-sectoral approach, the overrepresentation of persons living with mental illness within the justice system. One participant criticized the use of the phrase "income inequality" as a determinant of mental health, arguing instead that poverty itself, as opposed to simply disparity, is a major barrier to access. British Columbia, another noted, is the only province without a poverty reduction strategy.

Another related theme that was particularly pronounced was what one participant called the "structural discrimination" against mental health provision and care. While the global burden of mental health problems and illnesses in terms of cost is estimated to be about 25%, only 7% of GDP is invested in mental health services. As a result, only an estimated one third of the population in need is receiving primary care. The problem, as several agreed, is not simply one of funding and resources but also with how mental health continues to be marginalized. Despite the progress which has been made, some participants felt that the mental health field is still treated as an interest group and consequently lacks an equal voice at the table in broader conversations about public policy and social issues. This "separateness of mental health" was identified as a major area of concern.

Participants also agreed that questions with respect to how to better engage First Nations, Inuit, and Métis communities, as well as individuals with lived experience and persons with diverse sexual and gender identities, in planning and delivery remained vital, and that cultural competencies of the mental health system need improvement and enrichment. Some participants also felt that consultations and engagement needed to be more generally inclusive, and indicated they felt that the diversity of Vancouver was not adequately represented at the session.

Several participants noted that new technology, particularly communications technology (e.g. e-mental health services), is already helping to improve outreach and create a better culture of access.

Another important theme further touching on areas in need of improvement was the persistence of a crisis-driven model in place of something more systemic and far-reaching. One participant noted the extent to which the system still fails to interact with individuals in need until their conditions have become acute. Relatedly, some felt that there is a need for greater focus on transition points and concurrent disorders to roll back the crisis-driven model and stop people from falling through the cracks (when they, for example, transition from the justice system to the community or from youth to adulthood).

There was agreement on the importance of improving the case for investment in mental health, which one participant suggested might be achieved through the creation of shared measurement models and criteria for identifying potential returns on investment. Elsewhere, it was suggested that investments in mental health be branded as investments in future productivity and prosperity – an approach that some argued might make them more attractive to political leaders.

Participants agreed that access to affordable, supportive housing, in which housing serves as a platform for the delivery of other services and supports, remains a gap, and that the exclusion of substance use and addiction from the wider conversation remains a barrier.

As in other discussions, there was agreement on the need for better unified and collectively agreed upon measurements and metrics. However, this idea was complimented by a discussion of the relative merits of different types of metrics. One participant argued that the existing measurements place too much emphasis on avoidance of undesirable events – for example, the lack of hospital or emergency visits – and not enough on qualitative outcomes. Success should instead be measured on the basis of what we want to see achieved by both policymakers and individuals such as stable housing, the fostering of a sense of belonging, and the establishment of meaningful support networks.

During the discussion of priority populations, participants agreed that inequality exists among different groups in terms of how health and mental health care are delivered. While there was some agreement on the need for a general platform or universal model, there was also acknowledgement of the potential problems associated with isolating and targeting specific groups, especially when the issues and problems cut across them. As one participant noted, singling out and representing particular groups throughout the process can result in a needless competition for resources and risks reducing multifaceted populations to a series of disparate interest groups. As such, there is a need to continue building an approach that is universal and general, but also adaptable to complex needs.

When it came to their overall priorities at the national level, participants included: the ongoing gap between investment and need; continued outreach to marginalized and vulnerable groups; the integration of mental health and mainstream care; the need for an e-mental health strategy; the need for improved surveillance and data collection around mental health in Canada; and, further use of the Drive framework ("TEMPO") at the national level.

Edmonton and Calgary, Alberta – January 26–27, 2015

Three separate consultations were held in Alberta during the months of January and February 2015. Though all three were conducted along the same lines as the rest of consultations included in this report, the third, held in Calgary on February 2nd, was between MHCC staff and is therefore included in the "MHCC Family" section of this report.

The text below is an integrated summary of the January 26th and 27th consultations held in Edmonton and Calgary.

Participants in the Alberta consultations broadly echoed many of themes that emerged from other consultations. There was widespread agreement on the need for systemic and national change regarding the way we collectively perceive, communicate about, provide for, and treat mental health problems and illnesses. Additionally, participants expressed the need for greater integration of mental heath provision through early, pre-intervention education and screening. As in other consultations, participants also stated the need for the broad expansion of mental health services to meet demands.

Participants thought there needed to be more meaningful and sustained system collaboration. To this end, they cited the need to improve data collection and create better mechanisms for the compiling and dissemination of data and research. Better monitoring and reporting, participants said, would especially benefit people belonging to more vulnerable populations such as children and youth. Economic and funding incentives could also be used to foster increased collaboration.

Participants also felt that first responders and mental health service providers could be better included in discussions moving forward. Additionally, some suggested soliciting greater contributions from people and families with lived experience and treating everyone in a community, holistically, as a stakeholder.

Some participants felt that care continues to lack a family-focus. That is, it remains centered on individuals living with mental health problems and illnesses and therefore risks neglecting the caregiver or family unit as a vital component in recovery.

When it came to improving cultural competency, participants suggested that more should be done to determine the specific mental health needs of immigrants and refugees, as the latter have often endured greater trauma. Improving sensitivity towards LGBTQ and First Nations, Inuit, and Métis individuals and communities was also cited as an important goal.

Participants agreed that stigma remains a significant barrier to improving mental health provision and treatment and that work must continue towards the normalization of mental health. They also agreed on the need for expanded supportive housing for both youth and seniors as a means for improving access for vulnerable. Relatedly, access remains an acute problem for rural populations who tend to be further from service hubs and that the use of new technologies like e-mental health might help lessen urban/rural disparities.

When it came to the current infrastructure, some participants felt that existing funds are not being allocated as efficiently as they might be. A potential reason offered for this was that there remains inadequate infrastructure for assessing the actual effectiveness of ongoing strategies and initiatives and their outcomes. The process for identifying best practices, in other words, needs to be improved. This sentiment was elsewhere echoed by participants who called for the establishment of national accreditation standards to improve and enrich frontline practice. Relatedly, the institutionalization of common definitions and terminologies could help facilitate both improved data collection and joint national, provincial, and stakeholder efforts to combat stigma.

There was widespread agreement that a major priority should be the securing of greater funds for mental health provision and care representing a higher share (ex. 10%) of the total healthcare budget. Such lobbying efforts could potentially be assisted by building on the momentum of existing successes such as At Home and Chez Soi. Participants also wanted to see new funding for a wide variety of new programs or enhancements for existing ones. These included, but were not limited to: increasing caregiver support; increasing the presence of mental health provision in corrections; and training more mental health professionals.

The reduction of siloing was cited in several instances as a significant priority. An integrated and holistic national framework, it was suggested, would greatly assist the cross-fertilization of best practices and reduce barriers between provinces.

Saskatchewan Consultation, Regina – January 30, 2015

Seventeen individuals representing various parts of the province's mental health sector took part in discussions in small groups, reporting back to the room at large after each discussion. Since Saskatchewan was the first province to develop its own mental health strategy (the Mental Health and Addictions Action Plan for Saskatchewan), participants often used this as a reference point.

Representing a wide cross-section of the mental health sector, participants' work touched on all six of the strategic directions from the Mental Health Strategy for Canada. Some found it difficult to pin their work to a single strategic direction and a number felt it touched on several or even all of the six directions.

When it came to what they saw as the top priorities, participants were asked to vote. Increased education around mental health in the school system, increased access to high quality mental health clinicians, supports, and para-professionals, and continuing the intersectoral work begun as part of Saskatchewan's own action plan, were the top three priorities identified by the participants. Housing and the need for renewed lobbying to secure resources were also identified as important priorities.

One group identified current initiatives and projects in the mental health sector that they felt were working well, but required additional funding, focus, or uptake. These included: online CBT (Cognitive Behavioral Therapy); the reintegration of support services from one system to another (for ex. hospital to home); a primary health centre's pilot with a mental health practitioner on staff; and, the integrated provision of addiction service at Regina Correctional Centre.

The group also spoke favourably of an occupational therapist support project currently underway in Saskatoon, and of the United Way 211 initiative, which offers thousands of different services through a public hotline.

When it came to the top gaps and barriers to advancing better mental health care, there was agreement that prevention remained a pressing issue and that a more successful prevention strategy would involve multisectoral action during the early years of life. Relatedly, participants agreed that transition points require ongoing

strengthening to prevent people living with mental health problems or illnesses from falling through the cracks – particularly during the transition from youth to adulthood. There was also agreement on the need to lessen wait times, especially for people with mild and moderate mental health problems whose current waits often exacerbate mental health issues.

When asked to prioritize populations for the provision or expansion of mental health services, participants expressed some reservations about being selective, agreeing that all populations are important. First Nations, Inuit, Métis, and youth, however, were identified as particularly urgent populations of focus.

During this part of the discussion, one participant made the case that people working at primary healthcare sites such as family physicians and first responders should be seen as a key population to be working in an increased way in the future.

Participants made note of numerous efforts that they felt should be priorities on a national level. A major theme, which ran across several of the discussions, was the need for increased funding and the expansion of services. Though, as many agreed, there has been steady progress on a conceptual level – thanks to, among other things, increased public and stakeholder awareness of mental health, and the work of the MHCC – this progress is not translating adequately into implementation due to a lack of sufficient funding and resources.

More broadly there was recognition that mental health is a holistic issue that crosses all sectors and has profound social as well as economic consequences that go beyond the lived experiences of specific individuals. As such, participants agreed on the need to recognize the pan-sectoral nature of mental health and do more to reduce siloing. The need for the increased development of quality education and support for providers across spectrum (mental health workers, peer support, social workers, physicians) was also identified as an important priority.

A few more priority areas were noted, including: the need for quality data collection and sharing; continued work on suicide prevention and intervention with focus on adolescents; and, renewed work with corporate leaders to further leverage successful awareness and fundraising campaigns like Bell Let's Talk into further progress. Relatedly, participants suggested stronger business cases on mental health need to be made as a means of attracting and stimulating investment.

One area that emerged as a particular concern was pay for frontline staff, which some felt was currently inadequate. There was also agreement around the need for national standards around practices, training, and pay. To this end, some participants suggested developing a national peer support accreditation process in conjunction with the PSACC (Peer Support Accreditation Committee).

Winnipeg, Manitoba – March 27, 2015

Representatives at the Winnipeg dialogue overwhelmingly reaffirmed the need for increased funding, provision, and access for mental health services. Priorities and issues flagged as important also in many cases mirrored those of other discussions: reaching remote communities and at-risk populations, the need to emphasize prevention, improve cross-sectoral and interdepartmental collaboration, and combat stigma.

One group of participants felt that existing services fail to capture the full scope of mental health and are unable to tackle problems systemically. The result, as one panelist put it, is that organizations are providing support and arresting deterioration, but not effectively rolling back mental illness.

When it came to participants' priorities and those of their respective organizations, several wanted to see greater efforts focused on trauma and Post-Traumatic Stress Disorder (PTSD). Others favourably cited child and parent support programs such as Healthy Child Manitoba and the Positive Parenting Program. Continuing to improve general issues of literacy around mental health was also noted as an important priority. To this, some suggested embedding mental health and anti-stigma efforts in the post-secondary education curriculum. Relatedly, one group emphasized the importance of anti-stigma training for frontline workers such as border officers, police, and office managers. When it came to the workplace, one participant raised the promotion of "psychological safety" as a crucial workplace concept.

In terms of Manitoba's specific needs, one group noted the importance of, and need to improve, cultural sensitivity when working with First Nations in the north of the province and elsewhere. To this end, they cited a "personal approach" sensitive to individual needs as the appropriate outlook for care. One participant emphasized the need for longer-term therapeutic counseling, especially for children, youth, and adolescents.

Participants cited a number of areas where they felt conceptual frameworks or service delivery could be improved. In addition to arguing the need for greater collaboration, some felt that access to online services could be improved and that current mechanisms are still not very effective at connecting people with the specific services they need.

As in other consultations, participants repeatedly stressed the need to improve collaboration at all levels, but especially between first responders and mental health services. Better collaboration and improved knowledge sharing would allow new discoveries and/or best practices to be put in place quickly rather than in piecemeal.

One group felt that the inherently holistic nature of mental health – that is, its connection to a wide array of social determinants and policy areas – creates logistical problems when it comes to lobbying for resources because other departments and organizations are often in a better position to secure them. One participant also argued that stigma remains particularly acute around schizophrenia and other severe and persistent mental illnesses.

Several agreed that the separation between mental health and addictions is a serious problem, and one group recommended this be repaired through an institutional merger of the two fields.

In general, participants noted the benefit of stigma reduction programs, the evolution of language around mental illness, and its consequent mainstreaming. However, some participants noted the need to consider stigma a form of discrimination.

Even though the concept of stigma frequently arises in conversations about mental health, one participant argued, discrimination is how it is practically manifested and said this needs to be more widely acknowledged. The issue, it was said, is one of human rights and needs to be understood as such.

When it came to where they felt national efforts should focus, participants were fairly universal in their emphasis on structural and systemic change. One noted the lack of federal funding around social determinants of health pointing out, for example, that many First Nations children continue to go to schools that are underfunded and live in communities that lack basic necessities like clean water. Relatedly, some felt that a more equitable distribution of available services would better emphasize rural and remote areas

Several participants thought the immediate primary focus of the MHCC should be to secure a 12% share of GDP for mental health spending from all levels of government in Canada.

Mississauga, Ontario – July 29, 2015

In this meeting participants held an expansive and wide-ranging discussion about mental health priorities and the contours of Canada's mental health strategy going forward.

Early in the conversation, one participant strongly expressed the concern that current efforts are focused too much on process and abstraction rather than direct action. This sentiment was echoed by one or two other participants throughout the discussion, albeit in a less stringent fashion.

When it came to setting priorities, some groups made similar observations and recommendations. There was particular emphasis from several participants, for example, on the need to combat siloing – both at the level of funding and service delivery. Because mental health is an expansive and ultimately cross-sectoral issue, several observed that necessary funding is heavily siloed to the extent that it impacts the quality of services. Relatedly, data sharing and collection were cited as important priorities, with the latter currently suffering from, as one participant argued, from an imbalance of funding driven by funders' interests rather than need.

Another thread, as in other discussions, was the need for better outreach to diverse communities and, more specifically, the need for an approach to mental health that identifies those facing mental illness and other barriers like poverty and discrimination. Overall, participants seemed to agree on the need to develop greater culture competency throughout the mental health sector, incorporating the broadest definition of "culture" to include heritage, history, and gender.

Some participants observed that services remain unavailable to people in locations where they are urgently needed. While the promotion of helpseeking and prevention are good, they argued, these measures are ultimately inadequate if the services remain unavailable. One participant suggested that there should be incentives, financial and otherwise, for services providers to move to underserviced areas and regions.

The need to better incorporate lived experience – what one participant called the "concept of coproduction" was a major theme in the discussion. New stakeholders, it was argued, need to be incorporated into the process and, in particular, the policymaking process. In the current dynamic, some felt, individuals with lived experience are integrated more as a formality than as equal partners.

A recurrent theme was the perception of mental health throughout the country and the need to refine existing conceptual frameworks to better reflect reality and continue to reduce stigma. To this end, greater emphasis on the concept of mental wellness were repeatedly raised, something one participant referred to as a "humanist orientation" and contrasted with the notion of mental illness.

One participant argued that current policies around both ODSP and the CPP are creating structural barriers that limit some people's capacity to meaningfully participate in the workforce or in society more generally.

Other issues raised during the discussion included: the importance of housing and the role of homelessness in mental health; the need for better transitional services particularly during the transition from adolescence to adulthood, but also after retirement; the need for outreach to recent immigrants and refugees who may be unaware of the mental health services available; the need to investigate international models for care and consider how they could be implemented here, particularly when it comes to recovery.

Montreal, Quebec – June 29, 2015

Participants in the Quebec discussion cited an extensive number of priorities and objectives for the Mental Health Commission – and the broader mental health sector – to consider.

As in virtually all other discussions, the need to raise the overall profile of mental health and mental health literacy to reduce stigma was emphasized. In particular, participants felt that education and training around stigma reduction should be expanded and integrated into the public school system. Increasing the number of programs for improving mental health in the workplace, one participant argued, might also help to reduce stigma and raise the profile of mental health.

The need to support First Nations communities in correcting the shortage of services, support, and treatment – through funding, logistical support, or both – was also raised. In this regard, several participants indicated that they felt support and resources for aboriginal patients, particularly young patients, remains severely lacking. The need to integrate and raise awareness around the 94 recommendations made by the recently concluded Truth and Reconciliation Commission was also raised in discussions around First Nations issues.

There was a familiar emphasis on the need for a holistic approach to mental health incorporating its social determinants and cross-sectoral implications. Given that this can be a complex process, one participant suggested the best way to avoid compartmentalization and unnecessary bureaucracy is to approach each person as an individual whole.

Some participants felt that existing programs could be better diversified to ensure that they more directly target specific clienteles and, in particular, mothers, children, and youth. When it came to children and youth, some argued that new technologies could be better utilized to reach people under 35 and that innovation in E-Mental Health will be essential going forward.

Fredericton, New Brunswick – April 23, 2015

Though the discussion was very issue-focused, it was underwritten and informed by several broad themes.

The first of these was the need for a more intersectoral approach in mental health. Before the formal discussion had begun, one participant remarked on the absence of groups possessing of expertise and stake in the treatment and provision of mental health, including representatives from education, public safety, social development, nurses, family physicians, and, especially, police. This sentiment was echoed later in the consultation when several participants made the case that discussions of priority populations needed to become more multifaceted in order to adequately capture the complex vulnerabilities affecting different individuals. Relatedly, several populations were mentioned that had not appeared in the MHCC's materials. These included: International students, caregivers (parents, siblings, others), international visitors in Canada for extended stays, individuals with complex needs, offenders, and low-income individuals.

As in other discussions, the need for increased funding and resources was repeatedly stressed as was the general need for a holistic and systemic approach to mental health as a sphere with wide and cross-sectoral implications.

In discussing specific priorities from the perspective of their own organizations, some participants stressed the importance of housing, particularly for youth at risk. One cited the success of the "foyer" model in which housing for at risk youth is developed with a continuum of relevant services in the proximity, and recommended it be rolled-out at the provincial level. Others noted the importance of better outreach to rural communities and the problem of resource concentration in urban centers. Another agreed upon priority was the need for better mental health service provision for people charged with criminal offenses.

Many of these individuals, as one participant noted on behalf of their group, still lack proper access to service while others cannot get access until after they've been incarcerated, a situation that participants agreed needs to change.

Other priorities identified included stigma reduction, improved access for First Nations, Inuit, Métis, and youth, the need for more staff training on recovery-based care and rights-based advocacy, and more resources linked with domestic violence. When it came to stigma reduction, one group placed their emphasis on making use of educational tools such as new training at community colleges and sensitivity training across the sector to equip it to better serve the needs of diverse groups.

In discussing what is currently working, participants agreed that the increased involvement of grassroots community organizations and people with lived experience have been improvements. Additionally, within New Brunswick there has been increased cross-departmental collaboration and the forging of new relationships to enrich ongoing discussions around mental health as well as its provision. Such discussions have been strengthened, as one participant noted, by changes in privacy legislation, which have allowed departments to better share information.

Participants also agreed that the focus on vulnerable groups, such as youth, First Nations, Inuit, Mets, and seniors, has grown. The publication of addictions and mental health guidelines, soon to be followed by related operational directives, has also been an improvement. Participants also lauded the new focus of New Brunswick schools on positive mental health, resilience, and mental fitness. Also cited as improvements were the inclusion of mental health practitioners in family health teams and the province's poverty reduction strategy.

Participants also noted several other features of New Brunswick's approach to mental health that they felt should be adopted across Canada. These included: its recovery-oriented approach; its innovative Integrated Service Delivery model; its First Nations mental wellness project that has built capacity on reserves; the improvement of funding on post-secondary campuses for expanded mental health services and the awarding of scholarships through the Headstart programs, and peer mentoring. New Brunswick's collaborative approach, which has institutionalized conference calls between stakeholders every two weeks, was lauded.

When it came to areas in need of improvement, participants once again stressed the need for improved funding across all spheres of service and provision (mental health constitutes only 7% of total health spending). Though there was agreement that stigma reduction campaigns have enjoyed success, participants agreed that much more work remains to be done at both the provincial and national levels. In particular, as one participant noted, dominant language around mental illness still refers to it in a holistic rather than a condition-specific manner – making it quite different from how physical conditions are referred to and collectively discussed. Participants suggested that the MHCC could take a leading role in coordinating improved messaging in this and other associated areas of stigma reduction. On participant also argued that chronic diseases and mental health issues should be considered in tandem, rather than separate.

Also stressed was the need to emphasize the language of mental wellness and health over that of mental illness as a means of reducing stigma. This would allow for broader mental health outreach: not everyone is mentally ill, but mental wellness and fitness are relevant to all, just as physical fitness and health are.

As in other regional discussions, participants agreed on the need for national certification standards, the importance of a recovery focus (particularly in advertising), the need for agreement on messaging and language, and increased training and education. Participants made several more recommendations for systemic change at the national level. These included: lengthening the period of Employment Insurance coverage; holds on student loan interest for people on medical leave for mental health issues; and pharmacare for drugs related to mental health; and, the need for accessible and easy to use tools for the early identification of mental illness.

In general, there was agreement that more action and less deliberation is required. However, participants also noted that future engagement and discussion needs to be more inclusive and input-focused. Some felt that consultations hitherto have been too one-sided, and have merely sought validation for existing initiatives and strategies, rather genuine engagement.

Halifax, Nova Scotia – March 12, 2015

Two overriding themes dominated the Halifax consultation, both of which mirrored those of other consultations.

First, and crucial, was the need for improved funding and resources. Participants felt strongly that there are simply not enough services available for those who need them – especially vulnerable and remote populations – and that this situation is likely to be exacerbated by the success of anti-stigma campaigns that will increase demand. Unique to the Halifax discussion was the connection drawn between the lack of funding and the political and fiscal climate, which participants felt has been one of relative austerity for housing, healthcare, justice, education, and other spheres which impact mental health. This, compounded with the historic lack of funding afforded to mental health provision, was identified as a severe problem by several participants.

A second and related theme was the need for a holistic approach to mental health that is more cognizant of its underlying social determinants and the interplay of complex, multilayered forces in shaping outcomes. One participant felt strongly that an awareness of social determinants should precede any discussions of how to provide for, or respond to, the needs of specific populations.

When it came to issues, gaps, and barriers, participants made several notable observations. One individual noted with concern that the allocation of funding for research is primarily driven by large providers, who tend to have more say in determining best practices. Another suggested that evidence-based practices are too dominant across the field and that mental health researchers and providers should afford more attention to promising practices (that is, practices of potential that have yet to be properly tested or put to trial). This might be a route to newer and better practices. Other participants felt that there needs to be an improved evaluative framework to determine which practices are working well and which are failing or underperforming.

As in other discussions the lack of effective transition services, particularly from childhood to adulthood, was identified as a gap. Also raised was the need to plan for and be more aware of coming demographic shifts. Education and better support for primary care were also noted as important potential areas of improvement.

In addition to the lack of access due to inadequate resources, participants also felt there was a general lack of public knowledge about existing services and how to access them. New mothers and children were identified by one group as a vulnerable population of concern, as were low-income individuals. Another group suggested that prisoners should be added to the list of vulnerable populations. One participant suggested extending the definition of "caregivers" beyond families and to professional caregivers.

Given the chronic lack of funding, one participant emphasized the growing importance of e-mental health and other innovations that may help compensate for a lack of frontline services.

Summing up priorities at the end of the discussion, one participant suggested that the status quo as far as funding is concerned is simply unsustainable, and that increased funding in mental health should be considered an investment.

> One participant felt that early intervention and education should be the MHCC's principle focus, and is the best route towards systemic change. Early intervention combined with enriched transition services, they argued, would provide the building blocks for support across the entire life course, alleviating the burden on both treatment and care.

Charlottetown, Prince Edward Island – March 5, 2015

The broad themes of the Charlottetown consultation overlapped substantially with those touched on in others. Participants stressed the need for improved access to mental health services as well as the clear and present need for more resources and funding to meet demand and expand provision.

While barriers remain particularly pronounced for rural and remote residents, as well as those suffering from concurrent disorders, participants noted that wait times remain uniformly too long for all patient groups.

As in other discussions, they also cited ongoing stigma as a barrier to the effective identification and treatment of mental health issues. Relatedly, there was agreement around the need for national efforts to combat stigma by way of a communications strategy with consistent messaging and sustained funding. Both seniors and youth were identified as priority populations.

Another theme was the need for improved knowledge exchange between mental health stakeholders, particularly at the national level. Such a process could gather, synthesize, and disseminate information in a unified way such that provinces could focus more on implementation. Some participants felt that both knowledge exchange and interprovincial collaboration would be strengthened and improved through a formal system of accreditation, standards, and operational guidelines.

As for further priorities, participants reiterated the need to fight stigma at a national level in a coordinated and focused way. While there was agreement on the need for new resources, particularly for transitional services, some participants felt that more of the existing resources should be allocated to frontline work and not back office salaries which, they argued, are currently too high. New national funding, it was agreed, should to be tailored to the needs and contingencies of particular regions and localities to be maximally effective (housing needs in PEI, to take a single example, are different than they are in Toronto or Montréal).

A particularly notable suggestion was that federal transfer payments made to provinces for healthcare might be specifically tied to mental health and addictions funding.

Also spoken about was the need to formally integrate addictions and mental health at the national level, in line with PEI's own model. Participants suggested that the MHCC might collaborate with the Canadian Centre on Substance Abuse to this end.

St. John's, Newfoundland and Labrador – March 5, 2015

Though many of the broad themes touched on during the Newfoundland and Labrador consultation were similar to those that appeared in other discussions, participants had both a strong local focus and an attention to detail when it came making specific suggestions and identifying concrete areas for potential improvement.

As in other conversations, there was broad consensus on the need for expanded services and programs. In identifying gaps and issues, participants spoke of the need to better integrate and harmonize mental health provision by creating vertical and horizontal continuums of support accessible to people of all ages. Both a lack of effective transition services and improper treatment of mental health by the justice system were identified as gaps. Relatedly, participants spoke about the need for more pre-intervention work, such as life skills and resiliency training.

There was also agreement that service access remains a barrier, and is sometimes exacerbated by a lack of knowledge about the services available.

Participants also identified, as an emerging issue in need of a more integrated approach, the problem of dual diagnosis, in which individuals sometimes fall through the cracks because their conditions do not fall directly within the purview of any single part of the system.

Another theme was the need for increased sensitivity to the diverse needs of both individual people and communities. Participants agreed that access to both translation and interpretation, as well as broader diversity awareness remains limited – particularly for immigrants and the hard of hearing. Increased housing, and the need for better use of technology in outreach to rural and remote communities were also identified as issues. One participant wanted to see a greater specific focus on the issues associated with men's mental health.

When it came to barriers, participants spoke about the ongoing problems associated with stigma and the continued lack of effective cross-sectoral collaboration between different parts of the health system (e.g. between mental health and medicine). Also mentioned was the lack of involvement of families and people with lived experience at the institutional and policy levels in decision-making, particularly those in poverty.

It was also observed that increased demand is placing a severe logistical burden on existing services. As one participant noted, Newfoundland and Labrador alone is faced with about 800 new referrals a month, and matching each of these to the relevant aspect of care of service continues to be a challenge.

Setting priorities moving forward, participants agreed upon the urgent need for more safe and affordable housing – particularly in Newfoundland itself where housing prices are rising. The importance of early intervention and education – extending even to those yet to become parents – as well as the integration of mental health into the school curriculum, were also emphasized as priorities.

Some participants suggested that siloing could be reduced, not only through improved knowledge exchange but also by making available tools more user-friendly and accessible to grassroots organizations doing work on mental health.

Participants once again spoke of the justice system and the criminalization of the mentally ill. As was noted, 60% of inmates in Newfoundland's prisons have one or more issue associated with mental health or addiction, and 4% have been diagnosed with a severe mental illness. One participant argued that the federal government must take steps to ensure that people with severe mental health issues never end up in prison.

First Nations, Inuit, Métis, Northern, and Territorial

Iqaluit, Nunavut – March 24th, 2015

Though the issue of resources underlies every conversation about mental health included in this report, it was of special concern to the participants in the Nunavut dialogue because of the particular geographic realities and challenges in the North:

Nunavut represents a full fifth of Canada's entire land mass, contains twenty-six fly-in communities, and has only 36,000 inhabitants spread throughout it. This, as participants agreed, presents unique challenges that are partly visible in a suicide rate that is high relative to the rest of Canada (though, as was noted, it has dropped significantly).

Scarce resources creates pressures and difficulties that cut across and undermine the effectiveness of all sectors, as was very evident from the contributions made during the Iqaluit dialogue. In addition, participants said, the chronic lack of resources and progress creates frustration, undermines trust, and further exacerbates mental health problems and illnesses. The difficulties in effectively communicating, even when there has been success, also remain a unique challenge.

Participants noted that scarce resources pose particular challenges for Nunavut's correctional sector. A full 25% of inmates have been diagnosed with a mental health problem or illness and, though a strategy exists for correctional mental health, there have been difficulties regarding its implementation. The territory's four facilities suffer from overcrowding, and homelessness among recently released inmates is acute.

Participants agreed that increased attention needs to be paid to care and to transitional housing when it comes to individuals who have exited facilities – many of whom, as was observed, are simply dropped off on the street with no support. One possibility that emerged was the creation of a "wellness court" in the North that would work where possible to keep people with mental health problems or illnesses out of the criminal justice system.

Another theme was how the general lack of resources and capacity has affected the educational system where, participants observed, there is insufficient money to service different communities in their local languages and dialects. However, it remains important to treat different indigenous groups on their own terms rather than lumping them together when it comes to formulating a

Some argued that failed federal policies were a cause of some of the continued problems. Participants also suggested that territorial governments continue to be underrepresented in national conversations, where provinces are often represented by much larger delegations. Others raised the issue of stigmas associated with Nunavut and the North as an underlying problem.

strategy for mental health. Inuit groups, for example, now have their own mental health counseling available, but some of the terminology remains inadequate and potentially stigmatizing. This issue was also raised in relation to other indigenous communities. Participants repeatedly emphasized the need to approach different indigenous groups in a manner sensitive to their distinct languages and traditions.

As in other consultations, the need to embed mental health in the educational system and curriculum was a recurring feature of the discussion. The importance of prevention and strategies aimed at early childhood, with a particular focus on addiction as a component of mental health, was also a major theme. There was a general consensus that any long-term solution must have an emphasis on youth. Early education between grades 6 and 10 related to addiction, as some noted, will help reduce stigma and prevent addictions before they begin. Elsewhere in the conversation, participants stressed the need to better include youth in discussions in place of exclusive engagement with elders.

When it came to what was currently working, the panel agreed that there was a general willingness to create new partnerships and that quality of life groups were working effectively to share resources. There was also agreement that existing resources in Nunavut were being put to good use, despite their relatively limited nature.

The two biggest priorities, it was agreed, should be lobbying for new resources and making new capital investments. Any new resources should be invested in frontline services: a wellness court; better treatment facilities; more housing (those who cannot get space in hospital are currently lodged in RCMP jails); and, better life skills training. Any future funding needs to be sustained and long term, with its application practical and results-driven.

Yellowknife, Northwest Territories – May 22, 2015

As in other territorial discussions, a major theme of the Yellowknife consultation was the unique challenges posed by the Northern context, where the lack of resources to meet demand is compounded by both geographic and logistical issues.

While the inadequacy of resources and funds available for mental health was a major theme in all consultations, participants here made special note of the implications of this shortage in the territories. To take one illustrative example raised by a participant, wait times in the Northwest Territories not only remain arduous but many patients must travel to cities like Edmonton to receive actual treatment. As a result of the remoteness of services, necessary follow-ups often do not occur, and the lengthy wait times sometimes exacerbate mental health problems or illnesses.

Another major theme was the cultural contingencies of the North and how they create additional challenges for service delivery and provision. Several participants noted that many useful educational materials are only available in English and often only exist in printed form. Several suggested they be made simpler, more user-friendly, and available in other formats such as video.

Cultural sensitivity was also raised as a potential area for improvement, and one participant suggested that more work needs to be done to de-stigmatize the terminology around mental health problems and illnesses as a means of drawing more people to available service.

Youth emerged as a key vulnerable population, particularly when it comes to psychiatric services. One participant asserted that many youth in need are not admitted to facilities if the correct staff members are not present and noted that even in Yellowknife, which is a service hub, services cannot meet demand.

When it came to meeting the needs of remote communities, one participant noted the success of a local outreach effort in which single practitioners were deployed to a number of smaller communities where they worked directly with locals, drawing on local knowledge and strengths.

When asked about national priorities, participants made several notable suggestions. One, for example, argued that the scope of the Canada Health Act should be expanded to encompass psychological care – currently out of reach to many Canadians in need. Several stressed the need for increased spending on housing and the need for a national

housing strategy. There also appeared to be a strong consensus around the need to better recognize the root causes of mental health problems for First Nations, Inuit, and Métis and create better historical awareness (an Elder who spoke near the beginning of the discussion spoke about the legacy of Residential Schools, and their role in creating many of the current problems).

Several participants felt that, due to a lack of resources but also an incorrect approach, the system remains too crisis focused, and not geared enough towards the whole spectrum of early identification, prevention, and education.

Whitehorse, Yukon Territory – May 22, 2015

Though participants had some trouble agreeing on which of the six strategic directions their organizations are most focused, there was agreement, as in other discussions, around the need for a holistic approach that deals with mental health systemically and structurally.

When it came to noting the priorities of their respective organizations, conversations at the Whitehorse consultation very much mirrored those at others. Several participants cited the importance of improving collaboration between organizations – specifically through improved data collection, use of technology, and information sharing. Also raised as priorities were increased hiring and training of frontline providers and other staff, continuing work to de-stigmatize mental health, and increasing the volume of services available. At least one organization cited the accessibility of affordable housing as an important challenge and area of focus. Another called for a national and provincial push around suicide prevention.

Rural youth were mentioned as a specifically at risk population that needs greater attention. The need to reduce disparities between the provinces and territories, and for national organizations to focus more than they currently do on the latter, were seen as an overriding priorities.

When it came to what is currently working, there was widespread agreement that public awareness of mental health and mental health issues is increasing, and that stigma is being reduced. There was also agreement that efforts to establish a relationship between mental health and substance abuse were having an effect. Some participants felt that work to better provide for seniors were successfully improving conditions.

As a territorial consultation, several issues were discussed that were more specific to challenges faced in the north. A current problem area, as one group noted, is that some important mental health services are currently not available on the weekend. Providing services at home, increasing support for elders to keep them in their home communities, combating elder abuse, and loneliness in remote communities were also cited as priorities.

As for what they felt currently was not working, participants emphasized the inadequacy of mental health services currently available in the criminal justice system. In general, there was some agreement that service provision across most areas of the Yukon fails to meet the demand, particularly for at risk populations in rural areas. The importance of self-care, both as an individual and collective concept in the field of mental health, was also mentioned as something that needs more emphasis. Distribution of either current or prospective funding remains a challenge in a geographically large and demographically diverse jurisdiction like the Yukon.

Participants seemed to echo the sentiment that was common to other northern and territorial conversations: namely, that more substantive and effective collaboration with First Nations will be an essential component of any future strategy or action plan for mental health.

First Nations – Winnipeg, Manitoba – March 25, 2015

In this discussion, MHCC representatives met with a variety of stakeholders, many of whom are concerned with mental health access and provision from a First Nations perspective.

Given the unique needs of First Nations communities, much of the discussion focused on strategies for collaboration moving forward and the relationship between the emerging Mental Health Action Plan and the existing First Nations Mental Wellness Continuum Framework (FNMWCF).

A broad theme of the discussion was the extent to which the existing priorities and objectives of First Nations and the MHCC are in harmony or conflict. Representatives agreed on the importance of the FNMWCF and that its implementation represents the next step moving forward. There was also agreement on the need to identify linkages and commonalities between the Mental Health Action Plan and the FNMWCF as a means towards better collaboration.

Several participants emphasized the need for First Nations and their distinct needs to be represented in the MHCC's Action Plan, stressing that a "melting pot" approach would be inadequate and ineffective. The need to separate the diverse needs of First Nations, Inuit, and Métis, and to form different partnerships between the MHCC and each group, was also stressed. There was also concern that the priorities expressed by First Nations stakeholders would not make it into the Action Plan, and that the MHCC had not acknowledged the FNMWCF strongly enough. The existence of two separate plans for implementation, it was noted, creates competition for resources and fosters

siloing. A provisional solution that could form the basis for wider cooperation, as one participant from the MHCC noted, will involve finding complimentary strategic priorities between the different mental health strategies. Also mentioned was the possibility of integrating language from the FNMWCF into the Action Plan.

As in all other discussions, the issue of funding was front and centre. In addition to their expressed concern about the inadequate attention being paid to indigenous perspectives on mental health, several participants also felt that First Nations groups are treated as secondary when it comes to funding allocation.

Métis National Council – January 27, 2015

An early and prominent theme of the Métis National Council was the manner in which some resources has been allocated to organizations that work on a pan-Aboriginal rather than Métis-specific ones.

Several participants asked questions about the MHCC's role and the pan-Canadian nature of its strategies. It was noted, for example, that the MHCC has developed adaptations of Mental Health First Aid (MHFA) with Inuit and other First Nations communities, but has yet to develop a Métis adaptation. There were several other cases that some participants felt demonstrated the inadequate representation of Métis perspectives in conversations about mental health, for example the fact that Ontario's Métis Nation lacks a seat on its Mental Health Leadership Council.

One issue of particular concern to the panel when it came to funding, data, and implementation was the fact the health accords (those in BC were cited specifically) almost exclusively cover on-reserve First Nations, not Métis or urban Aboriginals.

Much of the discussion was a review of existing and emerging Métis-specific mental health programs and initiatives across the country. These included: the upcoming launch of the first Métis Family Health Clinic in Canada, located in Edmonton; the Métis Nation of Ontario's Working Group on Violence Against Aboriginal Women, upcoming Métis Mental Health Summit, and community wellness services; and the Métis Life Framework in Manitoba. In Saskatchewan, resources remain quite limited and there is only one staff member focused exclusively on Métis mental health.

When it came to priorities moving forward, one participant wanted to see greater focus on recovery. Another emphasized the importance of prevention and noted the Métis Nation of Ontario's advocacy for more investment in that sphere of mental health. Several expressed the need for increased information sharing between those concerned with Métis mental health in different parts of the country, and possibly the creation of a database or platform to better facilitate such exchanges.

One participant felt there should be a Métis-specific action plan for mental health, a sentiment that seemed like a broad theme throughout the discussion. As in all of the consultations, participants felt strongly that they were under-resourced relative to the level of need.

Inuit National Health Committee, Hopedale, Labrador – April 22, 2015

Participants at the Inuit National Health Committee felt strongly that their issues often go overlooked and a chronic shortage of funding remains a serious problem.

Several described the current conditions for Inuit mental health as being at the crisis level noting, for example, high rates of suicide. The institutional response, they argued, has not been adequate and, though there has been sympathy expressed in the media and other outlets, there has been little concrete action.

Some participants felt that stronger Inuit governance and more robust Inuit representation in decision-making bodies would be a precursor to improving mental health conditions. The character of this representation was also discussed, with some arguing that the MHCC should allow Inuit Tapiriit Kanatami (ITK – a national body representing Inuit) to appoint a representative for its board who would be charged specifically with bringing the Inuit perspective to the table.

When it came to what they wanted to see the MHCC prioritize going forward, there was overwhelming support for a national Inuit-focused strategy around suicide prevention. However, some concern was expressed about the effectiveness of labeling strategies as being about "suicide prevention" – presumably, though not explicitly due to issues around stigma.

While they approved the content of the MHCC's initial strategy and expressed respect for its work, participants said they needed to reflect more on how the Inuit community could fit into the strategy and play a part in bringing the Inuit-specific reality into the wider national conversation.

There was general agreement that all Aboriginal peoples remain underrepresented in funding and engagement, but particularly Métis communities. The First Nations Health Authority, which works with the federal government, has developed an Aboriginal Mental Health Plan of its own but there has yet to be input from Métis Charter communities.

The Mental Health Commission of Canada (MHCC) Family

MHCC Advisory Council, Ottawa – February 12, 2015

In an initial overview of shared issues related to mental health, many points of emphasis were in common with those of other sessions.

Issues related to stigma, access to services, child and youth mental health, complex needs, mental health promotion, intervention in the early years and for maternal and parental mental health, First Nations, Inuit, and Métis mental health, addictions and concurrent disorders, and issues related to mental illness and the justice system, were all identified as issues shared across the country.

Gaps in provision and service delivery were also noted. These included: a failure to recognize or take note of the social determinants of health as roots causes of mental health problems and illnesses; the link between physical and mental health, recognizing community-based, ground up approaches, peer support programs, court diversion programs, culturally competent services for First Nations, Inuit and Métis peoples, services for youth, concurrent disorders, and addiction treatment services.

The various organizations represented on the panel said that improved access to services and housing were priorities for them, as was improving general mental health literacy throughout the population. The reduction of suicide rates through new services in First Nations, Inuit and Métis communities was also identified as a priority, as was developing better mechanisms to measure government system performance through a report card. Some participants cited programs and services for youth and maternal mental health, though others also wanted to see a focus on middle aged men due to their extremely high rates of suicide.

Some felt strongly that all priorities should be related to concrete action rather than further data collection or research. However, when asked about their priorities at the national level others cited the lack quality data as a problem and felt a priority should be the creation of a unified mental health database. More specifically, one group raised the idea of integrated technical assistance centers in each province as a means to support the implementation of psychosocial interventions run by the MHCC. As in other consultations, one suggested priority was the integration of mental health literacy into school curriculums.

In general, participants felt that the state of access to mental health services is not improving and that ground is actually being lost when it comes to funding. Partly as a result, there is a concurrent lack of affordable housing, adequate peer support networks, and psychological health and safety is not properly being implemented at the government level. Some participants also noted an absence of much needed data around suicide prevention.

MHCC Youth Advisory Council, Ottawa – March 20-21, 2015

Despite representing a different demographic, members of the MHCC Youth Advisory Council had many perspectives in common with participants at other consultations.

As participants noted, there continue be problems with wait times and transitions from one part of the mental health system to another because of lack of coordination across services and sectors. Participants also raised the issue of the overrepresentation of persons will mental illness in the criminal justice system and emphasized the importance of recognizing the relationship between mental health and addictions.

Some felt that PTSD and other trauma-related conditions are not being adequately addressed. Others cited the growing income gap, with its concurrent implications for family debt, food security, and healthy eating, as an important phenomenon to be cognizant of moving forward. One group cited the lack of involvement from people with lived experience, and noted the ongoing challenges associated with recruiting and retaining a sufficient array of mental health human resources to properly serve the needs of diverse communities.

When it came to the priorities they wanted to see at the national level, members of the Youth Advisory Council agreed with other sessions on the need for a broadly holistic approach, citing a number of specific areas for focus. As a basic structural issue, they expressed the need for improved funding and efforts to secure it. Like others, they wanted to see models for intervention and services that recognize the complex social determinants of mental health.

When it came to the role of the MHCC, some suggested that it should function as a grant provider, distributing funds for mental health to other organizations.

Participants cited the need for support for people and organizations without access to grant money or knowledge of how to apply for it. One group put forth the idea of a "mental health annual," similar in character to a yearly physical health examination. Others expressed the importance of increased access to mental health guidelines and system navigation assistance tools in schools, workplaces, government offices, and hospitals.

Staff Consultations, Ottawa and Calgary — February and March, 2015

Because the discussions were closely related, the three panels involving MHCC staff that took place in Ottawa (February 10th, March 3rd) and Calgary (February 2nd) are included holistically in this section. What follows is an integrated summary of all three, bringing together the collected observations and discussion points from these three sessions.

At the fore during all staff discussions, participants noted the vital importance of de-stigmatization efforts in furthering the goals of the MHCC and enriching the quality of mental health treatment and provision across the country.

Participants observed that mental health is not perceived in the same manner as physical health, a reality that makes mobilizing around it considerably more difficult. As a consequence, vital services like homecare or its equivalent are not currently available for mental health-related issues.

Participants expressed optimism about the growing use of peer support and the ways in which social media is being leveraged. They also cited the effectiveness of current training programs and education, developing alternatives to medicine, ongoing anti-stigma efforts, and increased public awareness of mental health as causes for optimism. Housing First programs, the adoption of some standards around mental health in workplaces, the increased use of e-mental health to reach out and expand the conversation also emerged developments that should be looked on favourably.

As for pressing issues, barriers, and gaps, participants noted the continued problems of access for many people suffering from mental illness, and the persistence of stigma and continued lack of awareness in some areas around mental health. In common with other consultations was the widespread observation of a lack of sufficient resources, both for organizations doing mental health-related work, and for individuals and families in need of treatment or services.

They also felt there was a general lack of systemic awareness across the country when it comes to mental health and consequently a lack of a holistic, lifetime approach in addressing problems. Others noted that many hospitals

and emergency rooms are not sufficiently specialized around mental health crises and argued better training is needed to address this. Participants also agreed in general that more political involvement is needed when it comes to a variety of issues related to mental health. Another gap they identified was the observable lack of mental health efforts in the workplace when it comes to some small and micro-businesses, which may be more difficult to touch with outreach.

More specific suggestions included, but were not limited to: peer support for all ages; addressing isolation; mobilizing leaders to keep mental and physical illness on an even keel; better use of e-mental health; standardized methods of data collection; government mandated training for mental illness; the centralization of knowledge and information through a national database; ensuring that institutions across all sectors of society are equipped to deal with mental health issues on a long-term basis and the advent of built-in training for managers, teachers, and others; better promotion of self-care; and the increased involvement of families and persons with lived experience in decision-making.

When it came to discussing the role of the MHCC, there was widespread celebration of its achievements as a catalyst organization. Efforts so far have helped foster collaboration, reduce siloing, combat stigma, and aided in the compiling of information, creating new partnerships and enriching existing ones, bringing together organizations with competing interests, and forging better ties with government. However, some staff participants said they wanted to see a somewhat more activist and action-oriented role going forward.

When it came to setting national priorities, participants noted the need to expand access to services and to focus more on youth and other at-risk populations – in part by integrating mental health into school curriculums (a priority stressed in numerous other consultations). There was also a collectively recognized need for a systemic, holistic, and cross-sectoral approach to dealing with mental health.

Appendix A

Changing Directions, Changing Lives: The Mental Health Strategy for Canada's Six Strategic Directions

1 Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible. Reducing the impact of mental health problems and illnesses and improving the mental health of the population require promotion and prevention efforts in everyday settings where the potential impact is greatest.

2 Foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights. The key to recovery is helping people to find the right combination of services, treatments and supports and eliminating discrimination by removing barriers to full participation in work, education and community life.

3 Provide access to the right combination of services, treatments and supports, when and where people need them. A full range of services, treatments and supports includes primary health care, community-based and specialized mental health services, peer support, and supported housing, education and employment.

4 Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners. Mental health should be taken into account when acting to improve overall living conditions and addressing the specific needs of groups such as new Canadians and people in northern and remote communities.

5 Work with First Nations, Inuit, and Métis to address their mental health needs, acknowledging their distinct circumstances, rights and cultures. By calling for access to a full continuum of culturally safe mental health services, the Mental Health Strategy for Canada can contribute to truth, reconciliation, and healing from intergenerational trauma.

6 Mobilize leadership, improve knowledge, and foster collaboration at all levels. Change will not be possible without a whole-of-government approach to mental health policy, without fostering the leadership roles of people living with mental health problems and illnesses, and their families, and without building strong infrastructure to support data collection, research, and human resource development.