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CANADA

OUT OF THE SHADOWS AT LAST

Highlights and Recommendations

Final Report of
The Standing Senate Committee On Social Affairs, Science And Technology

The Honourable Michael J.L. Kirby, Chair
The Honourable Wilbert Joseph Keon, Deputy Chair

May 2006

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39th Parliament – 1st Session

The Standing Senate Committee on Social Affairs, Science and Technology

Highlights and Recommendations of the Final Report on
Mental Health, Mental Illness and Addiction

OUT OF THE SHADOWS AT LAST

HIGHLIGHTS AND RECOMMENDATIONS

Chair

The Honourable Michael J.L. Kirby

Deputy Chair

The Honourable Wilbert Joseph Keon

May 2006

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SENATORS

The following Senators have participated in the study on mental health and mental illness of the Standing Senate Committee on Social Affairs, Science and Technology:

The Honourable Michael J. L. Kirby, Chair of the Committee

The Honourable Wilbert Joseph Keon, Deputy Chair of the Committee

The Honourable Senators:

Catherine S. Callbeck

Andrée Champagne

Ethel M. Cochrane

Joan Cook

Jane Mary Cordy

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Marjory LeBreton

Viola Léger (retired)

Yves Morin (retired)

Lucie Pépin

Brenda Robertson (retired)

Marilyn Trenholme Counsell

Ex-officio members of the Committee:

The Honourable Senators: Jack Austin P.C. or (William Rompkey) and Noël A. Kinsella or (Terrance Stratton)

Other Senators who have participated from time to time on this study:

The Honourable Senators Di Nino, Dyck, Johnson, Kinsella, Lynch-Staunton, Mercer, Milne, Murray, Pearson, St.Germain, Stratton and Tardif.

ACKNOWLEDGEMENTS

The Committee wants to publicly acknowledge the enormous assistance it has received during the past two years from those who have worked so hard in helping the Committee to produce its reports on Mental Health, Mental Illness and Addiction.

In particular, the Committee wants to express its deep appreciation to the following people:

Dr. Howard Chodos and Mr. Tim Riordan Raaflaub of Parliamentary Information and Research Service, the full-time research staff of the Committee, have been deeply involved in all drafts of the reports that the Committee has released during this study. Mrs. Odette Madore was a key researcher on our first three reports on Mental Health and Dr. Nancy Miller Chenier was heavily involved in this final volume. The Committee is also grateful to the numerous other researchers from the Parliamentary Information and Research Service who worked on many of the individual chapters in this report. Without all their extraordinary help and commitment these reports would not have been completed in such a short time, nor in such a competent manner.

Josée Thérien, the Committee Clerk and her assistant, Louise Pronovost, were responsible for organizing all the meetings the Committee held on Mental Health, Mental Illness and Addiction, including scheduling the appearances of all the witnesses, for overseeing the translation and printing of all the reports, and for responding to thousands of requests for information about the Committee's work and for copies of the Committee's reports.

Dr. Duncan Sinclair, the former chair of the Health Services Restructuring Commission of Ontario, who without failure, gave generously of his time. His expertise, support and advice was welcomed and appreciated throughout the Committee's study.

We also want to thank the staff of each of the members of the Committee, who have had to endure a substantially increased work load over the past two years.

Thanks is also owed to Steve Lurie, for his extraordinary assistance on many of the technical aspects and cost estimates used in the report and Dr. David Goldbloom for his wise advice and counsel.

The Committee is indebted to Sheryl Pedersen, author of "Emmy's Story," which comprises the epilogue of this report.

To all of these people, we express our heartfelt thanks for a job very well done.

The Committee worked long hours over many months, requiring the services of a large number of procedural, research and administrative officers, editors, reporters, interpreters, translators, messengers, publications, broadcasting, printing, technical and logistical staff who ensured the progress of the work and reports of the Committee. We wish to extend our appreciation for their efficiency and hard work.

In *More for the Mind*, a study of psychiatric services in Canada, the Canadian Mental Health Association said:

In no other field, except perhaps leprosy, has there been as much confusion, misdirection and discrimination against the patient, as in mental illness... Down through the ages, they have been estranged by society and cast out to wander in the wilderness. Mental illness, even today, is all too often considered a crime to be punished, a sin to be expiated, a possessing demon to be exorcised, a disgrace to be hushed up, a personality weakness to be deplored or a welfare problem to be handled as cheaply as possible.¹

These words were written nearly half a century ago. Yet the more than two thousand personal stories submitted to the Standing Senate Committee on Social Affairs, Science and Technology by Canadians living with mental illness, and their families, make clear that these words continue to ring true.

It was difficult emotionally for Committee members to hear these stories. Listening to them, and reading them, had a profound effect on every one of us. As the months passed, they began to tear at our souls.

Committee members could relate to these stories because of their own personal experiences. Like any group of a dozen Canadians, we too have experienced the impact of mental illness in our families: a sister-in-law who has schizophrenia, a nephew who committed suicide, a daughter who battled anorexia for several years, a sister who lives with severe depression and has been in and out of psychiatric hospitals frequently; it is rare that a family has not been affected.

Indeed, it is this personal experience that has caused Committee members to regard our work on this report as much more than just another policy study: to us, it is truly a calling.

We know how difficult it will be to improve the lives of people living with mental illness. We know it will be tougher still to change deep-seated public attitudes and reduce the stigma and discrimination they face. To put each of them on the road to recovery will be an extraordinary challenge.

Yet we are optimistic that the time has come when meaningful change can, and will, be made. From coast to coast we have met politicians, government officials, mental health service providers and professionals, and many, many ordinary Canadians, who are willing to help make change a reality, to help bring people living with mental illness into the mainstream of Canadian society.

1 Canadian Mental Health Association, (1963) *More for the Mind: A Study of Psychiatric Services in Canada*, Toronto, p. 1.

We ask the readers of this report to join with us as, together, we work to transform mental health, mental illness and addiction services in Canada and to bring mental illness *Out of the Shadows at Last*.

To the people of Canada, I say welcome us into society as full partners. We are not to be feared or pitied. Remember, we are your mothers and fathers, sisters and brothers, your friends, co-workers and children. Join hands with us and travel together with us on our road to recovery.

Roy Muise — 9 May 2005 - Halifax²

² 9 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/15eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

INTRODUCTION

This is a summary of all but Chapters 1 and 2 of the final report of the Standing Senate Committee on Social Affairs, Science and Technology, “*Out of the Shadows at Last – Transforming Mental Health, Mental Illness and Addiction Services in Canada.*”³ The omitted Chapters give voice to people living with mental illness and their families. Readers are strongly encouraged to read them in their entirety to see the “human face of mental illness and addiction.”

The Committee has made a total of 118 recommendations which, together with the highlights of each Chapter, are the main focus of this summary.

Chapter 3 of the report (“Vision and Principles”) sets out the vision and key principles that guided the Committee in formulating its recommendations for transforming the organization and delivery of mental health and addictions services and supports in Canada. Because of its importance to understanding the Committee’s thinking, Chapter 3 is summarized in this document, even though it contains no recommendations.

In addition to Chapter 3, two other chapters of the report – Chapter 5 (“Toward a Transformed Delivery System”) and Chapter 16 (“National Mental Health Initiatives”) – have a broader role than the other chapters. Taken together, these three chapters provide the basic framework for all the Committee’s recommendations. Chapters 5 and 16 also contain key recommendations that affect the mental health and addictions “system” as a whole.

Each of the other chapters deals with a specific topic, be it a particular population group (e.g., children in Chapter 6, or Aboriginal peoples in Chapter 14) or specific issues (e.g., mental health promotion in Chapter 15, or self-help and peer support in Chapter 10).

The full report has been written for a general audience. Everyone touches, directly or indirectly, by mental health, mental illness and addiction issues should read it. The Committee encourages strongly those who have time only read this summary to read also, in full, those chapters referring to their particular interests and concerns.

The full report opens with the following excerpt from testimony by Helen Forristall, a young woman the Committee had the opportunity to hear in St. John’s, Newfoundland:

I do not like to admit it. I am ashamed and humiliated and I still have to work on that, but I am a mental illness consumer and I do take strong offence to stigma.

[...]

³ The full report is available online at the Committee’s website: www.senate-senat.ca/SOCIAL.asp or can be obtained by written request to the clerk of the Committee by e-mail at: soc-aff-soc@sen.parl.gc.ca or by mail at Chambers Building 40 Elgin Street, Room 1038, Ottawa, Ontario K1A 0A4.

My doctor told me I had a sick brain just like somebody else would have a sick heart and that is fine and well in a doctor's office, but in society, that does not work. People tell me to, "Snap out of it," and "Think happy thoughts." They recommend books to you and they lay this guilt trip on me, such as, "You are too young to be depressed," and, "You have nothing to be depressed about..." Again, I did not choose this. If I had breast cancer, nobody would question me.

When I came to my employers and told them that I was depressed, they said, "Well, you will have to prove that." I said, "I intend to. I have a note from a psychiatrist that says so. If you would like to see my purse, I have lots of pills that I have to take and I have to suffer through."

I also have to suffer through the indignity of being looked down on and it bothers me a great deal, so it is difficult to sit here [at the public hearing]. I find myself hiding behind my hair when there is a picture being taken because I still deal with the shame every day.

I wanted to say that I left my job last year sobbing [...]. I worked with the federal government. I left my job, July 9. I have not been back. I am on the status of leave without pay, leave undetermined. I have to fill out questionnaires monthly to prove that I am still mentally ill.

I had to beg my GP to have an appointment with a psychiatrist. I begged him, I pleaded with him and his response was, "Yes, well, he has 600 active patients. He is getting old and you do not really need this. Just keep on taking your drugs..."

[...]

I am in a program in Merchant House for which I had to wait six months to get an interview to be accepted into the program. I am glad to say I am in the program, but my counsellor has recommended that I go into group therapy, for which I am on two waiting lists. I am sixteenth on one list and she did not want to give me the number of the other list because it is much too long. She told me the program is supposed to last six months, but it ends up being two years or so because of the waiting lists.

[...] I have lost family and friends because they are afraid. The fear in this case is ignorance and I just have to deal every day with suicidal thoughts, medication, therapy and psychiatrists. It is not an easy road.

I would do anything to have breast cancer over mental illness. I would do anything because I [would] not have to put up with the stigma.⁴

⁴ 14 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

CHAPTER 3: VISION AND PRINCIPLES

In the background reports released in November 2004, the Committee affirmed that what is needed is a genuine system with people living with mental illness at its centre, clearly focusing on their ability to recover. This chapter describes what the Committee means by recovery and lays the foundation for what follows in the report.

It is necessary at the outset, however, to acknowledge with regret that the Committee has not been able to devote as much time and attention to substance use issues as it intended when it began this study of “mental health, mental illness and addiction.” The report focuses primarily on mental health issues

The Committee also points out that there is an emerging recognition that mental illness must be viewed with the same seriousness as physical illness. What the Committee means, then, by “treating mental illness like physical illness” is that both types of illness must be treated with equal seriousness, by providers, by all Canadians – and particularly by governments.

People who are living with mental illness and addiction must be accorded respect and consideration equal to those given to people affected by physical illnesses. The Committee has sought to make this one of the guiding principles that underpin its entire report. In particular, the Committee believes it is extremely important to stress the significance of what are called the social determinants of health in understanding mental illness and in fostering recovery from it.

This report focuses on facilitating the recovery of people living with mental illness and addiction. Recovery is not the same as being cured. For many affected individuals, recovery constitutes living a satisfying, hopeful, and productive life even with the limitations caused by mental illness; for others, recovery means the reduction or complete remission of symptoms related to mental illness.

The Committee believes that recovery must be at the centre of mental health reform. Even people with the most severe mental illnesses, some who have spent decades under institutional care, can and do recover. Although not everyone living with a mental illness will be able to recover, the Committee believes that recovery should be the primary goal around which the reformed mental health delivery system is organized.

While advocacy groups have been central in promoting this focus on recovery, increasingly it has been embraced both by the broader mental health sector and by governments. The Committee has concluded that a policy approach based on the concept of recovery must acknowledge the following:

Each person’s path to recovery is unique;

Recovery is a process, not an end point;

Recovery is an active process, in which the affected individual takes responsibility for the outcome, with success depending primarily on collaboration among helping friends, family, the community, and professional supports.

Working toward a recovery-focused system is a complex undertaking that rests upon three pillars:

Choice: Access to a wide range of publicly-funded services and supports that offer people living with mental illness the opportunity to choose those that will benefit them most;

Community: Making these services and supports available in the communities where people live, and orienting them toward supporting people living in the community;

Integration: Integrating all types of services and supports across the many levels of government and across both the public/private divide and the professional/non-professional dichotomy.

In general, the range of choices available to consumers of mental health services has been severely limited. Viewed from the perspective of fostering recovery, choice is both a means to an end – a more responsive service – and is also an end in itself. This is because the availability and exercise of choice is itself a potential contributor to the recovery process.

The Committee believes that it is people living with mental illness themselves who should be, to the maximum extent possible, the final arbiters both of the services that are made available within the overall mental health system and of the ways in which they are delivered.

Furthermore, no single treatment model should be allowed to dominate the policy horizon, either in theory or in practice. Many affected people will find successful treatments or care that are derived from a purely “medical” model, while others will look to their particular community or cultural traditions for ways of achieving the best mental health possible.

There is an institutionalized bias built into the way public funding for health care services works in Canada; under the *Canada Health Act*, only services that are provided by physicians or in hospitals are *required* to be publicly funded. While other services may be funded by individual provinces or even at the community level, access to them will vary widely. Current funding arrangements mean, therefore, that many services needed by people living with mental illness and addiction are available only to those who can pay for them out of their own pockets, or who have private insurance plans that cover their costs.

Policy decisions about which services and supports should be widely available and accessible to those who would choose them must be made on the basis of the best available evidence as to their effectiveness. Consumers of mental health services and supports must also be given the opportunity to participate actively in the process of collective decision-making. Their collective voice must be heard at the policy table, just as they should be allowed to make individual choices about which services and supports are right for them.

An orientation to providing access to community-based services and supports is the second pillar needed to support the creation of a recovery-oriented system. The evidence is clear that the shift begun many years ago away from institutionalized models of care was the

right one, even if in practice it was not always sufficiently resourced. Since mental health and addiction problems cut across so many facets of community life, much more than health care is required.

There is strong evidence that with the proper supports in place, those living with serious mental illness can not only live in the community but can lead fulfilling and productive lives. An orientation towards the community will mean something different for people experiencing mild to moderate mental health problems. For most of them, contact with the mental health system will occur through a primary health care provider (group or solo), who may or may not connect them subsequently with a specialized mental health service of some kind.

Epidemiological data indicate that, each year, roughly 3% of the population will experience a serious mental illness and that another 17% or so will experience mild to moderate illness. The full range of services must be available therefore to address the needs of people affected by illnesses in both broad categories.

Within the health sector, on the one hand, mental health services must be integrated with physical health care services. On the other, the variety of mental health treatments and services funded by ministries of health must also be integrated with the broader range of services required by people living with mental illness that are the responsibility of the several governmental departments and agencies that deal with income support, housing, employment, etc.

Finally, integration also requires that services and supports be available to people throughout their lifespan and that as people's needs change with aging or other circumstances they must still be able to gain access to appropriate services and supports in a "seamless" fashion.

The Committee believes it important to allow regions and communities to pursue forms of integration that are appropriate to their particular situations and circumstances. Integration must be seen as a means to achieving that goal and not as an end in itself – it must serve the objective of improving the range, affordability, quality, and accessibility of services.

CHAPTER 4: LEGAL ISSUES

The right to privacy of persons living with mental illness and addiction, and the impact of that right on their family caregivers, is an issue that has been raised repeatedly by witnesses at public hearings since the Committee began its work over two years ago. In the subsequent public consultations there has been extensive comment and debate on this topic as well.

Dealing first with the right to privacy for children and youth, parents want and need full information about the health of their children. The claim of access to personal health information by family caregivers is clearly strengthened when a child is involved. Nevertheless, the Committee appreciates that, prior to achieving the age of majority, some young people may be fully capable of deciding who should have access to their personal health information and to what extent.

Given the lack of consistency across Canadian jurisdictions with respect to applicable privacy legislation, and varying capacities on the part of children and youth to consent to their own treatment, the Committee recommends:

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| 1 | That the provinces and territories establish a uniform age at which youth are deemed capable of consenting to the collection, use and disclosure of their personal health information. |
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Some witnesses suggested that health care professionals were not doing enough to ensure that existing legislation governing access to personal health information was applied consistently and to its fullest extent. The Committee believes that health professionals have an important role to play in improving the flow of information among persons living with mental illness, their families, and third parties. Therefore, it recommends:

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| 2 | That health care professionals take an active role in promoting communication between persons living with mental illness and their families. This includes asking persons living with mental illness if they wish to share personal health information with their families, providing them with copies of the necessary consent forms, and assisting them in filling them out. |
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| 3 | <p>That health care professionals have discretion to release personal health information, without consent, in circumstances of clear, serious and imminent danger for the purposes of warning third parties and protecting the safety of the patient.</p> <p>That this discretion be governed by a clearly defined legal standard set out in legislation, and subject to review by privacy commissioners and the courts</p> |
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Making advance directives and appointing substitute decision-makers is a relatively simple process. If it were to be widely employed, it would ensure family access to personal health information while also preserving the autonomy and dignity of those living with mental illness. Thus the Committee recommends:

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| 4 | <p>That all provinces and territories empower mentally capable persons, through legislation, to appoint substitute decision makers and to give advance directives regarding access to their personal health information.</p> <p>That provisions in any provincial legislation that have the effect of barring persons from giving advance directives regarding mental health treatment decisions be repealed.</p> <p>That all provinces and territories make available forms and information kits explaining how to appoint substitute decision makers and make advance directives.</p> <p>That all provinces and territories make available community-based legal services to assist individuals in appointing substitute decision makers and making advance directives.</p> <p>That all provinces and territories undertake public education campaigns to educate persons with mental illness, and their families, about the right to appoint a substitute decision makers and make an advance directive.</p> |
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The Committee is aware that pre-planning will not occur in every case. It is important, therefore, that a legal mechanism be put in place to fill the gap. Therefore, the Committee recommends:

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| 5 | <p>That where a person is diagnosed with a mental illness that results in his/her being found mentally incapable, and where there is no previous history of mental illness or finding of mental incapacity, and where there is no named substitute decision maker or advance directive, the law create a presumption in favour of disclosure of personal health information to the affected person’s family caregiver(s).</p> <p>That the provinces and territories enact uniform legislation setting out this presumption.</p> <p>That the legislation specify an “order of precedence” for relatives (i.e., if the person is married, or living in a common-law relationship, disclosure would be to his or her spouse or common-law partner, and if there is no spouse or common-law partner, to the person’s children, etc.).</p> <p>That the legislation specify the information to be disclosed, including: diagnosis, prognosis, care plan (including treatment options, treatment prescribed, and management of side-effects), level of compliance with the treatment regime, and safety issues (e.g., risk of suicide).</p> <p>That the legislation specifically bar the release of counselling records.</p> <p>That the legislation oblige the person disclosing the personal health information to notify the mentally incapable person, in writing, of the information disclosed, and to whom it was disclosed.</p> |
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Part XX.1 of the *Criminal Code* sets out a comprehensive, independent regime governing accused persons who are found either unfit to stand trial or not criminally responsible for an offence on account of mental disorder. In all cases, the law requires that Review Boards impose the least restrictive disposition necessary (i.e. order setting out the detention, supervision or release of a mentally disordered accused person).

The Committee was alerted, however, to the fact that information needed by Review Board members to make appropriate dispositions is not always available. Courts have authority to order assessments at any stage of the proceedings against the accused. The Committee is persuaded of the need to increase the powers of Review Boards and therefore recommends:

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| 6 | That the <i>Criminal Code</i> be amended to grant Review Boards the same powers to order mental health assessments as those it currently confers on courts. |
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The issue of involuntary treatment is highly contentious. Having said that, the powers granted to courts by the *Criminal Code* permit involuntary treatment in very limited circumstances. Therefore, we recommend:

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| 7 | That the <i>Criminal Code</i> be amended to grant Review Boards the same powers to order treatment as those it currently confers on courts. |
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The Committee is concerned that the Criminal Code does not currently provide a way to deal with convicted persons who become unfit (by reason of mental disorder) to be sentenced after a verdict has been reached. Therefore, we recommend:

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| 8 | That the Government of Canada, in consultation with provincial and territorial ministers responsible for justice, develop proposed amendments to the <i>Criminal Code</i> to address the issue of convicted persons who become unfit to be sentenced after a verdict has been reached.
That these amendments be brought before Parliament within one year of the tabling of this report in the Senate. |
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CHAPTER 5:

TOWARD A TRANSFORMED DELIVERY SYSTEM

During its hearings, the Committee was pleased to learn that its vision of a recovery-oriented, primarily community-based, integrated continuum of care reflects a strong national consensus on the broad outlines of what a transformed mental health system should look like. This consensus is based on consistent and compelling Canadian and international evidence that increased provision of services and supports in the community is highly beneficial for people living with mental illness.

Community-based models of care have been shown to be largely equivalent in cost to the institutionally-based services they replace; they cannot be considered primarily as cost-saving or cost-containing measures. Neither need a community-based system be more expensive than an institutionally-based one.

What is required is the right blend of institutional and community-based supports and services. The key issue is to ensure that those services are available in the community and that people have access to a seamless continuum of care across their lifespan.

Community-based services are being developed in many regions of the country but there is still much to be done to allow people living with mental illness to have access to the services and supports they need. The services and supports available in each community will depend on many factors that are unique to its particular history and circumstances. The Committee does not believe it wise to attempt to dictate a uniform model.

Given that it offers so many advantages to people living with mental illness, and yet costs no more once the transition is complete, the question arises as to why governments have not been able to complete the transition to a community-based system. The most important reason for this relates to the dynamics of transferring existing financing from the institutional to the community-based sector.

Three points should be borne in mind. First, the savings that will eventually accrue from downsizing the institutional sector do not materialize all at once; they accumulate gradually as institutional services are phased out. Second, because phasing out of the old system and introduction of the new one both take time, the two systems must be operated in parallel over a considerable period of time; this too is costly. Third, over the period of time necessary to, for example, close a big institution, there is no guarantee that the money saved will remain within the mental health sector.

For these three reasons the Committee believes that a Mental Health Transition Fund (MHTF) must be established to allow the Government of Canada to make a time-limited investment to cover the transition costs and to accelerate the process of developing a community-based system mental health system. The Transition Fund approach is the most appropriate way for the federal government to invest in the delivery of mental health services – a provincial responsibility. The provinces and territories must decide how to allocate the transferred money.

It is legitimate, however, to expect that the federal government, and Canadians generally, should be assured that the money is: (a) spent on mental health projects; and (b) used to increase the total amount spent by each jurisdiction to enhance mental health and treat mental illness. Disbursement of the fund should be managed by the Canadian Mental Health Commission (see Chapter 16). The Committee believes that it is possible to establish a set of procedures, overseen by the Canadian Mental Health Commission, that would ensure that Transition Fund money was spent as intended.

Therefore, the Committee recommends:

9	<p>That the Government of Canada create a Mental Health Transition Fund to accelerate the transition to a system in which the delivery of mental health services and supports is based predominantly in the community.</p> <p>That this Fund be made available to the provinces and territories on a per capita basis, and that the Fund be administered by the Canadian Mental Health Commission that has been agreed to by all Ministers of Health (with the exception of Quebec).</p> <p>That the provinces and territories be eligible to receive funding from the Mental Health Transition Fund for projects that:</p> <ul style="list-style-type: none"> • Would not otherwise have been funded; that is, projects that represent an increase in provincial or territorial spending on mental health services over and above existing spending on services and supports, plus an increment equal to the percentage annual increase in overall spending on health; and that • Contribute to the transition toward a system in which the delivery of mental health services and supports is based predominantly in the community. <p>That in allocating the resources from the Mental Health Transition Fund priority should be given to people living with serious and persistent mental illness and that a strong focus should be maintained on meeting the mental health needs of children and youth.</p>
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The Committee believes the Mental Health Transition Fund should have two main components: a Mental Health Housing Initiative (MHHI) to provide federal funds for the development of new affordable and appropriate housing units and for rent supplements to permit people living with a mental illness, who could not otherwise afford to do so, to rent accommodation at market rates, and a Basket of Community Services (BCS) that will assist provinces to provide people living with mental illness with a range of services and supports in the community.

It would be hard to overestimate the importance of adequate housing for people living with mental illness, in particular those whose illnesses are serious. Three inter-connected dimensions must be addressed: more housing units are required; more assistance is needed so that people can afford to rent existing accommodation at market rates; and more supportive services are needed so that people can live in the community.

The investment required in new supportive housing and supportive services for people living with mental illness cuts across areas both of federal and provincial/territorial responsibility. Thus, the Committee believes that federal support for these services and supports should be channelled through the Transition Fund administered by the Canadian Mental Health Commission. The Committee recommends:

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| 10 | That services and supports directed at enabling people living with mental illness to be housed in community settings be eligible for funding as part of the Basket of Community Services component of the Mental Health Transition Fund and administered by the Mental Health Commission |
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The Committee believes that the first two interconnected dimensions described above (to build new units and provide rent supplements) should also be channelled through the Transition Fund. However, in managing the housing portion of that Fund, the Canadian Mental Health Commission should make use of existing federal structures and bodies, such as the Canada Mortgage and Housing Corporation, that are already responsible for affordable housing initiatives.

The Committee therefore recommends:

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| 11 | That, as part of the Mental Health Transition Fund, the Government of Canada create a Mental Health Housing Initiative that will provide funds both for the development of new affordable housing units and for rent supplement programs that subsidize people living with mental illness who would otherwise not be able to rent vacant apartments at current market rates. <ul style="list-style-type: none">• That in managing the housing portion of the Mental Health Transition Fund, the Canadian Mental Health Commission should work closely with the Canada Mortgage and Housing Corporation. |
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Many services and supports in addition to housing are needed in order to enable people living with serious mental illness to live safely in their communities. The recommendation below is not intended to be prescriptive; it recognizes explicitly the need for local flexibility, subject only to the condition that the services be community-based.

The Committee recommends:

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| 12 | <p>That a Basket of Community Services that have demonstrated their value in enabling people living with mental illness, in particular those living with serious and persistent illnesses, to live meaningful and productive lives in the community be eligible for funding through the Mental Health Transition Fund.</p> <p>That this Basket of Community Services include, but not be limited to, such things as Assertive Community Treatment (ACT) Teams, Crisis Intervention Units and Intensive Case Management programs, and that the only condition for establishing the eligibility of a particular service for funding through the Mental Health Transition Fund be that it be based in the community.</p> |
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Most people who seek professional help for a mental health problem will likely see a physician first, rather than a psychologist, social worker, or other provider. The Committee believes it important to encourage implementation of collaborative care initiatives in the development of an integrated, community-based continuum of care. Collaborative care is the most promising strategy to improve both access to, and the quality of, treatment and services at the first-line level.

The idea of collaborative care builds on ‘shared care’ initiatives that have been developed to promote greater cooperation between psychiatrists and family physicians. Collaborative care seeks to include a wide variety of mental health providers, consumers and family members in partnership. The Committee therefore recommends:

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| 13 | <p>That collaborative care initiatives be eligible for funding through the Mental Health Transition Fund.</p> <p>That the Knowledge Exchange Centre to be established as part of the Canadian Mental Health Commission (see Chapter 16) actively pursue the promotion of best practices in the development and implementation of collaborative care initiatives.</p> |
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Family members play an essential, sometimes lifesaving, role in caring for persons living with mental illness. Almost 60% of the families of people living with serious mental illness are estimated to serve in the capacity of primary caregiver, usually with little guidance, support, relief or respite. Family caregivers are financially impacted in a number of ways, and the Committee believes that they should receive some form of financial assistance from government when they have to leave work temporarily to care for a family member who is mentally ill.

The Committee is aware that Compassionate Care Benefits are currently available to eligible Canadians through Employment Insurance (EI). However, these benefits are restricted to persons who have to be absent from work to provide care or support to a gravely ill family member at risk of dying within 6 months. The Committee believes that it is appropriate to make Compassionate Care Benefits more widely available. Therefore, the Committee recommends:

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| 14 | <p>That compassionate care benefits be payable up to a maximum of 6 weeks within a two-year period to a person who has to be absent from work to provide care or support to a family member living with mental illness who is considered to be at risk of hospitalization, placement in a long-term care facility, imprisonment, or homelessness, within 6 months.</p> <p>That eligibility for compassionate care benefits be determined on the advice of mental health professionals and that recipients of compassionate care benefits be exempt from the two-week waiting period before EI benefits begin.</p> |
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The responsibility of providing care and support to a family member living with mental illness can place caregivers at risk of burnout. To avoid it, the Committee believes that respite care services available to families must be significantly enhanced. Given the diverse needs of family caregivers, and recognizing that these needs may shift over time, it seems logical that a variety of respite care services should be made available. Therefore, the Committee recommends:

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| 15 | <p>That initiatives designed to make respite care services more widely available to family caregivers, and better adapted to the needs of individual clients as they change over time, be eligible for funding through the Mental Health Transition Fund.</p> |
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CHAPTER 6: CHILDREN AND YOUTH

The pre-school years present two challenges. The first is to identify and provide services to those children who are living with, or who are at risk of developing, mental illness. The second is to manage effectively the transition from early childhood (0-5 years) into the school system. Given these challenges, the Committee recommends:

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| 16 | That school boards mandate the establishment of school-based teams made up of social workers, child/youth workers and teachers to help family caregivers navigate and access the mental health services their children and youth require, and that these teams make use of a variety of treatment techniques and work across disciplines. |
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Making the school a site for the effective delivery of mental health services involves several key steps. First, its potential must be recognized. Second, those services must be relocated from other hospital or community-based sites, or established as new services. Third, teachers must be provided with the time and resources to take on this new, more involved role. Therefore, the Committee recommends:

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| 17 | That mental health services for children and youth be provided in the school setting by the school-based mental health teams recommended in previous section 6.2.1.
That teachers be trained so that they can be involved in the early identification of mental illness.
That teachers be given the time and the practical resources and supports necessary to take on this new role. |
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The issue of stigma and discrimination arises throughout this report. Nonetheless, the Committee feels it is necessary to emphasize here the importance of implementing early education and awareness about mental illness in schools. The rationale for targeting educational programs at younger people is simple. When resources are scarce, it is best to target information at those who are most receptive to it. Therefore, the Committee recommends:

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| 18 | That students be educated in school about mental illness and its prevention, and that the Canadian Mental Health Commission (see Chapter 16) work closely with educators to develop appropriate promotion campaigns in order to reduce stigma and discrimination. |
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The abrupt termination of essential services has been rightly characterized as akin to falling off a cliff. Yet this is what happens all too often when young people reach a predetermined age, a point in time when their eligibility for specified mental health services is cut off.

It is the responsibility of mental health professionals to work in concert to tear down barriers within and between the adult and children's systems. All treatment services, be they community, school, or hospital-based, should be fully integrated to ensure children and youth receive age appropriate interventions for as long as they are needed. Therefore, the Committee recommends:

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| 19 | That provincial and territorial governments work to eliminate any legislative, regulatory or program “silos” that inhibit their ability to deal in an appropriate fashion with the transition from adolescence to adulthood, and that they adopt the following measures: <ul style="list-style-type: none">• Determine age cut-offs for mental health services for children and youth by clinical, rather than budgetary or other bureaucratic, considerations.• Where age cut-offs are employed, link services for children and youth to adult services to ensure a seamless transition.• Where age cut-offs are employed, avoid any “gaps” of time where individuals are ineligible for treatment under both the children and youth and the adult systems |
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The Committee is of the view that both mental health and social services are critical to staying well. No person living with a mental illness should languish in a legislative void between the children and youth and the adult systems. To avoid this possibility the Committee recommends:

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| 20 | That provincial and territorial governments coordinate mental health and social services, and pay particular attention in this regard to ensuring that age cut-offs for social services for children and youth be synchronized with those established for mental health services. |
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Canadians have grown accustomed to hearing about a shortage of health professionals in this country. Neither the mental health system, nor the sub-system serving children and youth, has escaped this problem. It is not just a question of increasing the number of psychiatric specialists, however. Shortages of other mental health professionals who specialize in treating children and youth, including psychologists, nurses and social workers, must also be addressed. Therefore, the Committee recommends:

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| 21 | That governments take immediate steps to address the shortage of mental health professionals who specialize in treating children and youth. |
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While the Committee agrees that waiting times must be reduced, we realize that increasing the training capacity for those mental health professionals who specialize in treating young people will be a very lengthy process. Therefore, remedies to bring some relief in the near term must be explored.

We believe that tele-psychiatry, the use of alternative treatment models, and case conferencing, have that potential. These transitional measures will help to bridge the gap during a period of restructuring designed to enhance the ability of the mental health system to assist children and youth. Therefore, the Committee recommends:

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| 22 | That the use of tele-psychiatry be increased in rural and remote areas, to facilitate the sharing of mental health personnel who specialize in treating children and youth with these communities.
That tele-psychiatry be employed both for consultations and for the purposes of education and training of health professionals who work in rural and remote areas. |
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| 23 | That standardized, evidence-based group therapies be used, where clinically appropriate, to reduce wait times for children and youth who need access to mental health services. |
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| 24 | <p>That provincial and territorial governments encourage their health, education and justice institutions to work closely together in order to provide seamless access to mental health services for children and youth.</p> <p>That greater use be made of case conferencing so as to coordinate and prioritize mental health service delivery to children and youth.</p> |
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Children and youth whose bodies and minds are continually growing and changing pose a particular challenge to mental health professionals. Adapting treatment interventions to this reality is a delicate process, one that must be approached with a healthy respect for the client and his/her family caregivers. Where the family unit is dysfunctional it should be treated as a whole, with all family members provided the assistance they need.

Shifting to this model of service delivery will not be easy. It will require a change in mindset that, to date, has resulted in the mental health system being structured to suit the needs of institutions and providers, not clients. As a first step, it must be recognized that children and youth, and their family caregivers, are full and equal partners – capable of defining the solutions that best meet their own needs. The Committee strongly supports this approach and therefore recommends:

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| 25 | <p>That evidence-based family therapies be employed so that all family members are provided the assistance they need.</p> <p>That professionals interacting with children and youth with mental illness be offered training opportunities to ensure that they can properly address the mental health needs of their younger clients.</p> <p>That family-based treatment of mental illness be integrated into the curriculum of mental health professionals and primary care physicians.</p> <p>That professionals interacting with family caregivers be compensated for this time, in addition to the time spent with the young person living with mental illness.</p> <p>That all practitioners working with children and youth be trained in children's rights.</p> |
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CHAPTER 7: SENIORS

Seniors are a demographic segment with unique attributes whose mental health needs differ from those of other groups. They are not just older adults whose mental health problems can be addressed by the generic treatment programs supposedly suited to all ages.

At the same time, it is important to recognize that seniors are not a homogeneous group. They encompass a broad range of ages, and their mental health needs vary within these age-groups from youngest to oldest. Mental health service delivery, and the research that ought to underpin it, must take this diversity into account.

The failure of the mental health system to recognize the uniqueness and diversity of seniors' needs may be attributed in part to the lack of knowledge exchange amongst researchers in gerontology, as well as between those who provide care to geriatric populations and the broader community of mental health and addiction care providers. With this in mind, the Committee recommends:

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| 26 | <p>That the Knowledge Exchange Centre to be created as part of the Canadian Mental Health Commission (see Chapter 16) have as one of its goals to foster the sharing of information amongst gerontology researchers themselves, and also between providers of specialist care to seniors and other mental health and addiction care providers.</p> <p>That the Canadian Mental Health Commission encourage research on the broad ranges of ages, environments (i.e., community versus institutional), co-morbidities and cultural issues that have an impact on seniors' mental health, and that it promote best practices in senior-specific mental health programs in order to counter the marginalization of older adults within treatment programs that claim to be suited to all ages.</p> |
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The mental health system is provider-driven in that it is generally structured to suit primarily the needs of individual and institutional service providers, not their clients. The challenge posed to seniors by the provider-driven service model varies, depending on their role as caregivers to another family member, their personal financial resources, and the extent to which their mobility is restricted.

The Committee believes that, like those with physical health problems, seniors living with mental illness should be provided treatment and support services in their own homes. But medical or psychotherapeutic services alone are not sufficient. They must be supplemented to meet the additional needs of seniors, be they physical (e.g., assistance with the activities of

daily living – home maintenance, shopping, cooking, cleaning, or bathing) or social (e.g., visitors or access to library services).

The Committee strongly supports the principle that a full range of treatment and support services should be available for *both* the mentally and the physically ill. We also support the creation of affordable (i.e., subsidized) and supportive housing (i.e., housing options where assistance with the activities of daily living is available on-site). Therefore, the Committee recommends:

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| 27 | <p>That money from the Mental Health Transition Fund (see Chapter 16) be made available to the provinces and territories for initiatives designed to facilitate seniors with a mental illness living in the community; these initiatives could include, amongst other things, the provision of:</p> <ul style="list-style-type: none">• home visits by appropriately compensated mental health service providers;• a range of practical and social support services delivered in their homes to seniors living with mental illness;• a level of support to seniors living with mental illness that is, at a minimum, equivalent to the level of support available to seniors with physical ailments, regardless of where they reside;• a more widely available supply of affordable and supportive housing units for seniors living with mental illness. |
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In addition to recognizing the value of family caregivers and assisting them in that role, steps must be taken to minimize the risk of those caregivers developing mental illness themselves. In particular, caregivers should not be expected to stand in or substitute for services and supports that should be available to ill family members living alone in their own homes. The Committee recommends:

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| 28 | <p>That seniors with a mental illness who are living with family caregivers be eligible for all of the health and support services that would be available to them if they lived alone in their own home.</p> |
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The Committee believes that all Canadians should have access to the acute care system, when and where they need it. There are circumstances where seniors living with mental illness require hospitalization, and this service should be readily available to them. We also recognize, however, that many older adults are being inappropriately “housed” in acute care facilities. The solution lies in making alternatives to hospitalization more widely available.

When seniors can no longer be maintained in their own homes or with family caregivers, long term care facilities are often a next step. However, while the need of residents of “care homes” differs from past years, the consequences of these changes have not been adequately addressed. There has been an insufficient increase in staffing levels, not enough support for upgrading caregiver skill levels, and too little enhancement of on-site mental health and support services to meet the increased intensity and modification of care requirements that has been the result of this shift. The end result may be overmedication, the use of chemical restraint, provision of only the most basic or custodial needs – or, in short, “warehousing” of our society’s most vulnerable senior citizens. Alternatives are available. The Committee recommends:

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| 29 | <p>That efforts be made to shift seniors with a mental illness from acute care to long-term care facilities, or other appropriate housing, where it is clinically appropriate to do so, by making alternatives to hospitalization more widely available.</p> <p>That staffing competencies in long term care facilities be reviewed and adjusted, through the introduction of appropriate training programs, to ensure that the devolution of responsibility for patients living with a mental illness from acute care facilities to long-term care facilities is done in a way that ensures that clinically appropriate mental health services are available to residents on-site.</p> |
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While it cannot be predicted when people will make the shift from own home, to caregiver home, to hospital, to long-term care facility, what can be affirmed, sadly, is that the transition between these locations will not be seamless. At best it will be inefficient and inconvenient, at worst it may be unsafe.

There are a number of potential solutions to this problem. First, resources can be invested to help seniors and their family caregivers better navigate the existing system through the use, for example, of professional system navigators. Second, there can be greater centralization of transitional services in traditional locations, i.e., where service providers are currently based (pending implementation of the reforms recommended above). Third, services can be shifted to centralized locations, such as long-term care facilities, where many seniors live.

The Committee believes that the last option would provide the most benefit. However, we suggest that it be taken one step further. In addition to centralizing services in locations where many seniors live, we are of the view that different “homes” for seniors should be put in close proximity to one another, perhaps even under one roof.

This model has the advantage of addressing simultaneously problems associated with mobility and with making the transition from one housing setting to another. It also would accommodate situations in which aged couples with different care needs can continue to live in the different settings most appropriate to their needs but still be in close proximity to one another. Therefore the Committee recommends:

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- 30 That a range of institutionally based services for seniors living with a mental illness be integrated (e.g., supportive housing units and long-term care facilities) by locating them adjacent to each other, to make the transition(s) between different institutional settings efficient and safe.
- That every effort be made to facilitate aged couples being able to continue to live together, or in close proximity to one another, regardless of the level of services and supports that they each may require.

CHAPTER 8: WORKPLACE AND EMPLOYMENT

Surveys show that most persons living with serious mental illness want to work and see employment as a primary goal. But few are employed. This leads to impoverishment and reduced social engagement, which in turn may worsen mental and physical illnesses. Also, it contributes to feelings of worthlessness and depression, can lead to substance abuse, and results in dependency on income security programs for survival.

The workplace can contribute positively to mental well-being – it is where we derive a good part of our sense of social integration. Work has also been found to play an important role in recovery from mental illness. Ironically however, participation in the workforce can also contribute to the development of mental health problems, including stress, depression and anxiety.

There are two broad categories of mental health intervention in the workplace. First, primary prevention measures aim to eliminate, or at least reduce, factors in the workplace that have a negative impact on the mental health of the workforce. Second, there is a range of secondary intervention strategies designed principally to reduce the effects of stressful work situations by improving the ability of individuals to adapt to and to manage stress. Well-structured organizational approaches, however, generate more important, longer-lasting effects than secondary intervention strategies directed at individuals.

The Global Business and Economic Roundtable on Addiction and Mental Health has identified management practices or behaviours (e.g. creating a “treadmill” at work – too much to do, all at once, all the time) that can precipitate or aggravate mental health problems in the workforce. The Committee agrees with the Roundtable that a successful primary intervention strategy must attempt to modify these unhelpful practices, and therefore recommends:

31	That the Canadian Mental Health Commission (see Chapter 16) work with employers to develop and publicize best management practices to encourage mental health in the workplace.
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The lack of “mental illness literacy” amongst employees, managers and supervisors reduces the likelihood of speedy identification and resolution of mental health and addictions problems in the workplace. A further challenge stems from the fact that the health care system and the workplace are very different, with differing cultures, languages, practices and priorities. What is needed are boundary walkers – leaders who are versed in both mental health and employer issues and who can help to integrate disparate systems more effectively over time. The Committee therefore recommends:

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| 32 | That the Knowledge Exchange Centre to be created as part of the Canadian Mental Health Commission (see Chapter 16) assist employers, occupational health professionals and mental health care providers in developing a common language for fostering the management of mental illness in the workplace and in sharing best practices in this area. |
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Employee Assistance Programs (EAPs) are employer-sponsored programs designed to alleviate and assist in eliminating a variety of workplace problems. Typically, they provide counselling, diagnostic, referral and treatment services, and have a strong prevention component. They have their limitations, however, such as, the limited number of therapeutic sessions available to EAP clients that renders low the probability of success in effectively addressing any serious substance abuse or mental illness problem. Having this in mind, the Committee recommends:

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| 33 | That employers increase the number of counselling sessions offered through Employee Assistance Programs (EAPs), especially in communities where access to other mental health services is limited.
That research be undertaken to evaluate EAPs, and that the results be shared through the Knowledge Exchange Centre that the Committee recommends be created as part of the Canadian Mental Health Commission (see Chapter 16), with a view to strengthening the effectiveness of these programs. |
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Supported employment involves placing clients as quickly as possible into jobs without extensive preparation, while simultaneously assigning job coaches to provide ongoing, intensive on-the-job support and training. Supported employment models have produced more positive outcomes than have traditional vocational rehabilitation services.

Consumer development initiatives emerged as a response by people living with mental illness to the failure of traditional vocational rehabilitation programs to help them achieve their employment goals. Those affected began themselves to develop businesses which they both owned and operated. This is a promising way to move people living with serious mental illness into the workforce.

The Opportunities Fund is an employability program, administered by the Department of Human Resources and Social Development, for people with disabilities who have had little or no attachment to the labour force. In light of what it has learned regarding supported employment, and consumer development initiatives, the Committee recommends:

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| 34 | <p>That the Department of Human Resources and Social Development, through the Opportunities Fund for Persons With Disabilities, facilitate the establishment of a nation-wide supported employment program to assist persons living with a mental illness to obtain and retain employment.</p> <p>That this program promote the development of, and provide support for, alternative businesses that are both owned and operated by persons living with mental illness.</p> <p>That the Department of Human Resources and Social Development report on how many people living with mental illness are assisted through the Opportunities Fund for Persons With Disabilities</p> |
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In all provinces and territories, Workers' Compensation Boards (WCBs) receive an increasing number of mental health-related claims (referred to as "occupational stress"); in a growing number of cases, the Boards have provided compensation for such claims. Data are lacking, however, on the nature of these claims and on how much compensation was paid in each case. The Committee believes it is important that this issue be addressed, and recommends:

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| 35 | <p>That the Canadian Mental Health Commission (see Chapter 16) work closely with provincial and territorial governments as well as with Workers' Compensation Boards, employers and trade unions across the country to develop best practices with respect to compensation for occupational stress-related claims.</p> |
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People living with mental illness frequently have to turn to social assistance (i.e., welfare) programs operated by the provinces and territories. Strict eligibility criteria, including a requirement to first exhaust, at least in part, one's own financial assets, are only one of the problems associated with these programs. Benefits, while generally higher than those available to persons considered "able bodied" (i.e., employable), remain at a level that may result in financial hardship. Also, those who seek to return to work may be dissuaded by policies that would result in varying amounts of earned income being deducted from their benefit cheques, a loss of specific benefits (i.e., medical or drug benefits) or a loss of benefits altogether. Therefore, the Committee recommends:

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- 36** That benefit levels and earning exemption amounts for social assistance programs for persons living with a mental illness be increased to reduce financial hardship and increase the incentive to work.
- That recipients of supplementary aid, such as help with the costs of medication, continue to be eligible for assistance for an extended period of time even if their incomes increase to levels where they are no longer eligible for financial aid for shelter or other living expenses.

The federal government has two income support programs that may be of assistance to persons living with a mental illness: the Disability Benefit provided by the Canada Pension Plan, and sickness benefits provided by Employment Insurance. Tax assistance is also available through the Disability Tax Credit.

For many years, individuals with mental illness and addiction and their representatives have raised concerns that the Canada Pension Plan – Disability (CPP-D) does not address the question of mental illness and disability appropriately. To address these and other concerns, the Committee recommends:

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- 37** That the eligibility criteria for Canada Pension Plan — Disability (CPP-D) benefits be modified so that persons living with a mental illness are no longer required to demonstrate that their illnesses are severe and prolonged, but only that their illness has been diagnosed and that they are unemployable and need income support.
- That the Government of Canada review how to coordinate better Employment Insurance (EI) sickness benefits and CPP-D, and examine how to eliminate structural barriers (i.e., financial disincentives) that limit opportunities to return to work.
- That the Government of Canada grant authority to the CPP to permit it to sponsor research on, and the testing of, new approaches that could target people with episodic disabilities, particularly episodic mental illness.
- That the Government of Canada explore ways to provide incentives to employers who hire persons living with mental illness, including the possibility of offering them CPP premium “holidays”.

Individuals with mental illness and addiction may be eligible to receive EI benefits as temporary income replacement. The Committee is of the view that the criteria for EI sickness benefits should be modified so that persons living with a mental illness can qualify more easily for EI. Therefore, the Committee recommends:

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| 38 | That Employment Insurance (EI) sickness benefits be modified so that persons living with a mental illness can qualify more easily. Specifically, for persons living with a mental illness, the number of hours to be worked since the last claim should be reduced. |
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The Disability Tax Credit is a non-refundable tax credit that can be used by persons with disabilities to reduce the amount of income tax they have to pay. Qualifying for the DTC is not easy. To be successful, a person must have a severe and prolonged impairment that markedly restricts his or her ability to perform a basic activity of daily living. In any case, the amount of tax relief is small. To address these shortcomings, the Committee recommends:

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| 39 | That the eligibility criteria for the Disability Tax Credit (DTC) be modified so that persons living with a mental illness can qualify more easily, and that the amount of the DTC be increased. |
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CHAPTER 9: ADDICTION

A strong consumer and family self-help and advocacy movement has arisen in support of mental health services. With respect to addiction, self-help has been pervasive and has a long history – but with little government funding and sustained within a culture of anonymity and independence.

Individuals and families living with mental illness have successfully made the case to various provincial and territorial governments that the contributions of self-help organizations are so important that they must be funded. That this has not been achieved for addiction self-help groups points up the inequality of representation between two groups, *both* of which have crucial expertise to offer and important work to do. Therefore, the Committee recommends:

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| 40 | That a portion of the funding for peer support in the Mental Health Transition Fund (see Chapter 16) be made available to develop and sustain self-help and peer support groups for people and their families living with addiction (including problem gambling). |
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While the production and trafficking of illicit drugs grabs headlines, legally available substances – alcohol and prescription medication – have the greatest and most far-reaching impact on Canadians’ lives and health. The reality is that the vast majority of Canadians who are addicted use legally available substances. Therefore, the Committee recommends:

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| 41 | That treatment resources targeted at addictions include addiction to legal substances such as alcohol, tobacco, and prescription medications, and to behaviors such as gambling. |
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The prevalence of problem gambling has risen significantly over the past 25 years. In 1999-2000, the net profit to governments at all levels from gambling (after prizes and other expenses) was \$5.7 billion. By 2004, that profit had risen to \$6.2 billion, more than the net profit to government of tobacco and alcohol combined (\$5.9 billion).

Canadian governments at all levels depend on revenues from gambling and it is likely that investment in gambling facilities will be increased. But the social, economic and health impacts for Canadians are just beginning to emerge; they must not be ignored or minimized. Therefore, the Committee recommends:

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| 42 | <p>That provincial and territorial governments commit a fixed portion of funds derived from gambling to evidence-based prevention, awareness and treatment programs for gambling addiction, and to gambling addiction research.</p> <p>That Statistics Canada ensure that in addition to alcohol and drug use, the prevalence of problem gambling among the general population is measured and reported upon through regular survey work.</p> |
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As with other health problems, people who are poor, marginalized or otherwise disadvantaged suffer disproportionately from addictions, including problem gambling. Children and youth, women and seniors have particular vulnerabilities that may neither be recognized nor addressed. Therefore, the Committee recommends:

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| 43 | <p>That the Government of Canada conduct an assessment of the outcomes of existing programs dedicated to addiction problems for First Nations, Inuit and Métis peoples.</p> <p>That the results of this assessment be shared through the Knowledge Exchange Centre to be created as part of the Canadian Mental Health Commission (see Chapter 16) with a view to identifying successful treatment models and expanding these programs to improve access and reduce wait times.</p> <p>That the provinces and territories develop and implement evidence-based outreach, and primary and secondary prevention programs for at-risk populations — women, children and youth, seniors, and those affected by Fetal Alcohol Spectrum Disorders.</p> |
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The most cost-effective strategy in response to early-stage alcohol problems is a single session of advice from a primary care physician with follow-up by a nurse. Given this, the Committee recommends:

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| 44 a) | <p>That family physicians be trained, through medical school and professional development curricula, on diagnostic guidelines for Fetal Alcohol Spectrum Disorders (FASD). in the use of brief intervention and interview techniques to recognize problem substance use leading to addiction.</p> |
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That family physicians be trained, through medical school and professional development curricula, on diagnostic guidelines for Fetal Alcohol Spectrum Disorders (FASD).

While substance abuse can mask the symptoms of a mental illness, it can also exacerbate psychiatric symptoms. As a result, people with concurrent disorders (mental illness and addiction) generally have problems that are complex; they are very difficult to help.

Both the mental health and addiction “systems” have been slow to acknowledge even the existence of concurrent disorders. Typically, people with concurrent disorders cycle back and forth as clinician-specialists try to decide which problem to treat first. The results have been much less than satisfactory, primarily because of the disconnect between the two treatment systems with their differing philosophies. Given this, the Committee recommends:

44b) That the Government of Canada include as part of the Mental Health Transition Fund (see Chapter 16) \$50 million per year to be provided to the provinces and territories for outreach, treatment, prevention programs and services to people living with concurrent disorders.

Historically, mental health and addiction services have developed separately – each with its single focus. The two sets of services rest on differing philosophies relating to causes, effects and sources of help. But there are signs of convergence, not the least of which are the emergence of literature on best practices and treatment of concurrent disorders and the establishment of some joint services. It is now time for addiction and mental health services to build integrative mechanisms based upon their shared interests, views and, above all, the benefits to affected people that will follow.

The quadrant model is well-known among service providers in the addiction field. It has been endorsed as a “thinking tool” that helps conceptualize integration in a way that respects the differences between the mental health and addiction fields while, at the same time, offering opportunities for integration that can be acted upon fairly swiftly.

A D D I C T I O N	↑ High	Quadrant 3 A high level of addiction problems with a low level of mental illness SPECIALIZED ADDICTION CARE	Quadrant 4 A high level of addiction problems with a high level of mental illness SPECIALIZED INTEGRATED CONCURRENT DISORDER CARE
	↓ Low	Quadrant 1 A low level of addiction problems with a low level of mental illness PRIMARY CARE	Quadrant 2 A low level of addiction problems with a high level of mental illness SPECIALIZED MENTAL HEALTH CARE
		← Low	High →
MENTAL ILLNESS			

People with a combination of a low level of mental health and addiction problems (Quadrant 1) are by far the largest segment of society; they will seek help most frequently from a primary care physician. The quadrant model proposes that addiction and mental health services become concurrent disorder capable, meaning that those services must be able to recognize and respond to concurrent mental health and addiction problems. Only the small number who fall into Quadrant 4 require concurrent disorder specialized services.

The quadrant model does not value one service system over another. Nor does it presuppose the amalgamation of administration and services over the two fields, or the elimination of specialized programs. Instead, integrative mechanisms can be built locally to include: service agreements among mental health and addiction agencies; designation of local “lead” organizations that take on the roles of intake, assessment and referral; communication tools that facilitate the secure exchange of personal health information; and the use of distance technology to bring mental health, addiction and specialized services to remote or under-serviced areas. Having this model in mind, the Committee recommends:

45	That the Canadian Mental Health Commission (see Chapter 16) actively partner with national addiction organizations, and work toward the eventual goal of integration of the addiction and mental health sectors.
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CHAPTER 10: SELF-HELP AND PEER SUPPORT

While acknowledging that professional help is valuable, people and families living with mental illness are turning more and more to self-help and peer support as a substitute for, or as an adjunct to, hospital, community and professional (primarily medical) services. These substitute supports counteract stigma. They provide people a place where they are safe and welcome, something particularly important for clients who have been poorly served by the mainstream mental health system.

To be a full partner in one's own care or that of a loved one, accurate and complete health and service information is essential. People living with mental illness, and their families, lack access to even the most basic information. Harried professionals may offer few answers or communicate in ways that are hard to understand. As a result, many people and families living with mental illness believe that conversations with a peer and exchanges of information among those who have "been there" are indispensable. Therefore, the Committee recommends:

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| 46 | <p>That programs be put in place to develop leadership capacity among persons living with mental illness, and their families.</p> <p>That the Knowledge Exchange Centre (see Chapter 16) contribute to building this capacity by facilitating electronic access to information and technical assistance for people affected by mental illness and their families.</p> |
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In Canada, as elsewhere, *ad hoc* self-help and peer support programs have developed and grown without co-ordination. Although some have been funded by governments, most exist on shoe-string budgets independently of one another and struggle for survival. As a new and tenuous addition to the mental health and addiction system, their future remains insecure.

The Committee recognizes the value of self-help and peer support organizations and the financial difficulties many such organizations face across the country. Therefore, the Committee recommends:

47	<p>That funding be made available through the Mental Health Transition Fund (see Chapter 16) that is specifically targeted at:</p> <ul style="list-style-type: none"> • Increasing the number of paid peer support workers in community-based mental health service organizations. • Providing stable funding to strengthen existing peer development initiatives, build new initiatives (including family groups), and build a network of self-help and peer support initiatives throughout the country. <p>That the federal government lead by example, building on innovations such as the National Peer Support Program for current and former Canadian Forces members and support, with appropriate levels of funding, self-help and peer support programs for the client groups that fall under the jurisdiction of the federal government.</p>
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Research focused on self-help and peer support is relatively new, but the findings are promising. The theories that underpin the few studies that have been done and the methodologies employed are expanding the research horizon in new and innovative ways. Importantly, people living with mental illness, and their families, are participating in the formulation of questions as well as in data collection and analysis and the dissemination of results. Such knowledge transfer practices are taking mental health and addiction in evolving and promising directions. Therefore, the Committee recommends:

48	<p>That research be undertaken to:</p> <ul style="list-style-type: none"> • quantify the benefits of self-help and peer support to participants, • identify savings to the health care system that result from peer support initiatives, and <p>That a portion of these savings be redirected to support further self-help and peer support initiatives.</p>
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| 49 | That the Canadian Institutes of Health Research (CIHR) support research into self-help and peer support, and that in determining which research projects to fund the CIHR utilize a review process that welcomes and understands the types of participatory methodologies that persons living with mental illness, and their families, prefer and find effective. |
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New voices and views are often not taken seriously because those who advance them may speak from divergent points of view. They may not agree with one another. The language used may not be typical of the mainstream. With respect to people and families affected by mental illness and addiction, however, these disparate voices offer an opportunity for a richer, more nuanced dialogue among all stakeholders. They also provide a route to improved measures of accountability.

The “customers” of the Canadian mental health and addiction system have told the Committee that they cannot find services when they need them and that, when they are lucky enough to find help, they are often unhappy with the services they receive. These criticisms are not vague or insubstantial. They point exactly to what is wrong, providing valuable information that can serve to improve the targeting of future government investments and the accountability for the outcomes. Therefore, the Committee recommends:

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| 50 | That accountability measures for mental health and addiction services include not just process issues such as numbers of visits, hours of counselling or dollars spent, but also address outcomes, such as respect, preservation of dignity, as well as a focus on hope and recovery, since these figure amongst the things that persons living with mental illness, and their families, value most. |
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The accountability requirements that accompany funding by government and many granting bodies are onerous. Mainstream organizations often employ staff specifically to satisfy their funders’ reporting requirements. The burden of data collection increases steadily; mainstream programs are required to keep extensive electronic and paper records describing their service activities in relation to expenditures, all the while complying with security measures and privacy legislation. Self-help and peer support groups, by their very nature, do not ask for private health information; some do not even ask participants for their names or addresses.

While there are numerous examples of self-help organizations that compete successfully for grant money, receive government funds and raise funds through soliciting private donations,

most live perpetually on shoe-string budgets without the means to mount the initiatives needed by their members or to maintain a presence at important decision-making tables. Many such groups have difficulty acquiring funding because they challenge the very system through which grants and other money tends to flow. Some decide not to pursue government funding because of the pressures that may then be applied to change their ways of doing things. Having this in mind the Committee recommends:

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| 51 | <p>That accountability requirements that are established for self-help and peer support groups do not impose an overly onerous burden on these groups, and that measures be taken to ensure that these groups are able to meet these requirements.</p> <p>That consumer and family-led certification and accreditation processes for self-help and peer support programs be developed and funded to ensure quality, and to sustain the unique contribution of self-help and peer support initiatives.</p> |
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While mainstream organizations assert that a lack of funds compromises their effectiveness, marginalized groups are often told the opposite – that funding will spoil them. The Committee believes that the rewards of investing in self-help and peer support outweigh the risk that their cultures may be altered in either unpredictable or negative ways. The key is to balance financial support against independence and the capacity of self-help and peer support groups to meet necessary accountability requirements.

The rise of the self-help movement in mental health and addiction heralds a significant change in the traditional power relations in our systems of care. With sufficient and regular funding, combined with the ongoing commitment and protection of government, its full benefits will be realized. Therefore, the Committee recommends:

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| 52 | <p>That existing and new consumer and family organizations be funded at an annualized, sustainable level.</p> <p>That broad-based coalitions be funded and built among self-help and peer support organizations so that they do not continue to exist in isolation but are able to form networks with one another.</p> |
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CHAPTER 11: RESEARCH

Research is fundamental to provide the quality information needed for the effective planning and delivery of the whole spectrum of mental health services. It can lead to meaningful improvements in the lives of people living with mental illness and addiction in Canada. The Committee believes that it is of utmost importance that Canada devote the resources needed for effective research, dissemination of the results of research, translation of those results into clinical practice, development of a national research agenda, and collection of the data necessary to track mental health in Canada.

The Committee was told that the stigma associated with mental illness and addiction creates significant barriers to Voluntary Health Organizations (VHOs) attracting appropriate publicity, getting corporate sponsorship, and raising funds for the support of research; this contrasts with the experience of other disease groups such as cancer and cardiovascular disease. Given the difficulty faced by VHOs in raising funds, the Committee recommends:

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| 53 | That the Canadian Mental Health Commission (see Chapter 16) work with non-governmental health organizations to develop and strengthen their fundraising capacities in order to raise more funds for research on mental health and addiction. |
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The federal government could increase the funds available for research by forming strategic partnerships with the private and non-profit sectors. The main federal funding body for mental health research, the Canadian Institutes for Health Research (CIHR), does engage in some partnership activities, but they could be increased. Therefore, the Committee recommends:

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| 54 | That the Canadian Institutes of Health Research actively seek out more opportunities for research partnerships on mental health and addiction with the private and not-for-profit sector. |
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People living with mental illness, their family members, and representatives from Voluntary Health Organizations told the Committee of their desire to participate in research. For example, where appropriate, they could assist in the creation of research questions; their representatives could sit on review panels. The Committee therefore recommends:

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| 55 | That the Canadian Institutes of Health Research formalize the involvement of non-governmental health organizations, persons living with mental illness and family members in the setting of mental health research priorities and participation in peer review panels. |
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The Canadian Institutes for Health Research, through its Institute of Neurosciences, Mental Health and Addiction, is the dominant source of funds available throughout Canada for research into mental health, mental illness and addictions. Several witnesses told the Committee, however, that research funding does not correspond to the huge burden that mental illness and addiction places on society. The Committee is very concerned that insufficient resources are being devoted to research specifically relevant to mental illness and addiction. Hence, the Committee recommends:

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| 56 | That the Government of Canada commit \$25 million per year for research into the clinical, health services and population health aspects of mental health, mental illness and addiction.

That these funds be administered by the Canadian Institutes of Health Research (CIHR), through the Institute of Neurosciences, Mental Health and Addiction under the guidance of a multi-stakeholder board and in consultation with the Canadian Mental Health Commission (see Chapter 16).

That this \$25 million be incremental to the funding currently provided to the CIHR. |
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The total CIHR budget will also affect the funds available for specific research areas, including mental health and addictions. In its 2002 report on the state of the health care system in Canada, the Committee called for an increase in the federal government's annual contribution to health research to 1% of the amount spent on health care. The Committee reiterates its strong support of the 1% goal and recommends:

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| 57 | That the Government of Canada, within a reasonable time frame, increase its funding to health research to achieve the level of 1% of total health care spending. |
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A number of submissions to the Committee stressed the importance of research capacity. Some witnesses made the point that insufficient numbers of physicians and other health

professionals are participating in mental health and addictions research and that too few clinician scientists are being trained to carry out critical clinical trials. Therefore, the Committee recommends:

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| 58 | That the Canadian Institutes of Health Research, through the Institute of Neurosciences, Mental Health and Addiction, increase the funds available specifically for recruiting and training researchers and for clinical research on mental health, mental illness and addiction issues. |
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A major concern of researchers in mental health, mental illness and addiction is that there is currently no central database of funding available from all sources. Neither is there an authoritative source of information about on-going research. As a result, researchers find it difficult to negotiate their way through not only the government granting agencies, but also private and non-profit sector funding sources. The creation of such central databases would also help inform people living with mental illness, their families, and voluntary health organizations about what research is taking place. The Committee therefore recommends:

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| 59 | That the Knowledge Exchange Centre to be created by the Canadian Mental Health Commission (see Chapter 16) incorporate, amongst other things, an Internet-based database of research funding agencies and funding opportunities, identify what research is being conducted and where, and include summaries of research findings from all levels of government, universities, and non-governmental organizations.
That the Knowledge Exchange Centre also assist in the exchange of information by organizing conferences, workshops, and training sessions on mental health research. |
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Knowledge translation is about turning the knowledge gained through research into more effective services and products. Without effective knowledge translation, ineffective or even harmful treatments may continue, and effective, evidence-based treatments may not be adopted by policy-makers and mental health service providers. Yet, many witnesses told the Committee that knowledge translation is not done well in mental health and addiction research. Therefore, the Committee recommends:

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| 60 | <p>That the Canadian Institutes of Health Research (CIHR), through the Institute of Neurosciences, Mental Health and Addiction, substantially increase its efforts in knowledge translation in relation to mental health, mental illness and addiction research.</p> <p>That CIHR work closely with the proposed Knowledge Exchange Centre in order to facilitate knowledge exchange among decision-makers, providers and consumer groups.</p> |
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In the area of mental health, mental illness and addiction there is no coherent research policy or strategy in place leading to a coherent and coordinated response to the complex issues involved. Witnesses stressed the need for better coordination of efforts to deal with the many challenges posed by mental illness and addiction currently being undertaken by the federal and provincial governments together with non-governmental organizations and the pharmaceutical industry. Given CIHR's leadership role in funding health research in Canada, the Committee recommends:

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| 61 | <p>That the Canadian Institutes of Health Research, through the Institute of Neurosciences, Mental Health and Addiction, work closely with the Canadian Mental Health Commission (see Chapter 16), researchers, provincial and non-governmental research funding agencies, and organizations representing people living with mental illness or addictions in order to develop a national research agenda on mental health, illness and addiction.</p> |
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Canada also has no national picture of the status of mental health across the country. That is, we lack a national information base on the prevalence of mental illness and addiction in all their diverse forms. Collecting reliable data will provide better information for policy and decision makers inside and outside of government, as well as service providers and consumer groups.

The Public Health Agency of Canada has recently decided to develop a national mental illness surveillance program. A lot of work will need to be done, however, to provide a complete picture of the state of mental health in Canada. Therefore, the Committee recommends:

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| 62 | <p>That the Public Health Agency continue its efforts to develop in a timely way a comprehensive national mental illness surveillance system that incorporates appropriate privacy provisions.</p> <p>That the Public Health Agency expand the range of data collected in cooperation with other agencies, such as the Canadian Institute for Health Information and Statistics Canada, as well as other levels of government and organizations that collect relevant data.</p> <p>That, as it develops a comprehensive national mental health surveillance system, the Public Health Agency work with the Canadian Mental Health Commission (see Chapter 16).</p> |
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Research involving human participants must be designed and performed in accordance with the highest scientific and ethical standards and must protect the dignity of individuals and their families who make this valuable contribution to scientific progress. The Committee believes that the unique circumstances and vulnerabilities attending mental illness and addiction raises issues regarding the ethical design, review and conduct of research that may not be adequately covered by the current Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans. For example, the mental capacity of people living with mental illness to consent to participate in research can exist at different levels to varying degrees and can fluctuate over time. Consequently, the Committee recommends:

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| 63 | <p>That the Interagency Advisory Panel on Research Ethics conduct a study involving broad consultations as to whether the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans provides adequate protections and sufficient guidance for research involving persons living with mental illness and addiction. The panel should also explore the possibility of using patient advocates for persons with mental illness participating in research.</p> |
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CHAPTER 12: TELEMENTAL HEALTH IN CANADA

The concept of telemental health (telemedicine and telepsychiatry) refers to services for mental health care that are delivered at a distance through a variety of information and communication technologies (ICT). This technology can be used for a number of purposes including diagnosis, treatment, training, education and consultation.

The number of pilot projects and of local and regional telehealth programs has increased considerably over the past decade. Nevertheless, a common theme voiced by witnesses was that more resources are required before telehealth programs reach their full potential.

Telemental health is one of the most frequently used of all telehealth services because the process of psychiatric diagnosis is not primarily a physical one but relies instead on verbal and non-verbal communication. The most frequently cited benefit from the wider deployment of telemental health (and all telehealth services) is its capacity to increase access to mental and other health services in rural and remote communities. This is of particular importance for many First Nations and Inuit communities.

By providing “low-profile” services to users, telemental health also offers the added benefit of helping to address issues relating to the stigma associated with mental health care services.

Regulating and funding telemental health practice, however, requires licensing agreements among the various jurisdictions in which participating health professionals are located. While some jurisdictions have licensing agreements for cross-border practice, most do not. The Committee therefore recommends:

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| 64 | <p>That the provinces and territories work together to put in place licensing agreements and reimbursement policies that will allow for the development of telemental health initiatives across the country.</p> <p>That the Canadian Mental Health Commission (see Chapter 16) work with the provinces and territories to identify and resolve any outstanding licensing and reimbursement issues.</p> |
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Funding and sustainability are a major issue for many programs, particularly in the North where telecommunication costs are very high. The Committee believes it important for the federal government to assist with the deployment of telemental health initiatives across the country.

Over time, and once the infrastructure is in place, it should be possible for the provinces and territories to use the savings from reduced transportation and other costs that will be gained by implementing telemental health services to fund the operating costs of those services.

Meanwhile, to assist with the transition towards this “steady state,” the Committee recommends:

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| 65 | That telemental health initiatives be eligible for funding through the Mental Health Transition Fund (see Chapter 16). |
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In addition, Richard Alvarez, President and CEO of Canada Health Infoway (CHI), informed the Committee of the restriction in its funding agreement with the federal government concerning telehealth that CHI can cover only up to 50% of eligible costs of telehealth projects. The Committee agrees with Mr. Alvarez that this restriction should be eliminated and therefore recommends:

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| 66 | That the funding agreement between Canada Health Infoway and the Government of Canada be revised so that Canada Health Infoway is no longer limited to being able to cover only up to 50% of eligible costs of telehealth projects and is allowed to establish the same ratio for its investments in telehealth projects as it uses in other projects. |
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Without consistent and reliable evidence relating to telemental health as an effective method of care, health authorities and provincial/territorial health departments are understandably reluctant to fund new projects. The Committee therefore recommends:

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| 67 | That the Knowledge Exchange Centre (see Chapter 16) work with the provinces and territories, as well as with other bodies such as the Canadian Institute for Health Information, in order to measure the cost-effectiveness of telemental health care delivery compared to traditional mental health service delivery.
That the Knowledge Exchange Centre assist in the development of evaluation tools for telemental health services. |
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Many mental health care providers remain unfamiliar with telemental health, sceptical about its utility and, indeed, uncertain about their capacity to use it effectively. While some providers are now actively striving to acquire and develop the special skills needed to deliver care through telehealth, others are proving resistant. The Committee therefore recommends:

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- 68 That the Canadian Mental Health Commission (see Chapter 16) encourage the inclusion of telemental health instruction in medical schools, and that it work with the provinces and territories, as well as with the relevant professional bodies, to make information available on telemental health to current mental health providers through its Knowledge Exchange Centre.

CHAPTER 13: THE FEDERAL DIRECT ROLE⁵

The federal government has significant responsibility for programs and services related to the mental health, mental illness and addiction of seven diverse client groups: First Nations and Inuit; federal offenders; Canadian Forces members; veterans; RCMP members; immigrants and refugees; and federal public service employees. While acknowledging the distinct needs of each group, a comprehensive federal strategy is needed to improve the health status of all federal client groups. The Committee therefore recommends:

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| 86 | <p>That the federal government develop a strategy for mental health that is inclusive of all federal client groups and that takes into account each group's particular needs;</p> <p>That the strategy set goals, including a timetable for implementation and for subsequent evaluation;</p> <p>That the strategy have as its objective making the federal government a model employer as well as model provider with respect to its various clients.</p> |
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Historically, the federal government has been a leader in developing the concepts of population health. It must apply these concepts to its own clientele with respect to the provision of mental health service. The Committee therefore recommends:

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| 87 | <p>That the mental health strategy to be developed by the federal government incorporate a population health approach to the determinants of mental health, and that it specifically address the economic, educational, occupational and social factors that have an impact on the mental health of all federal clients;</p> <p>That the federal government report to Parliament in 2008 on what precisely it is doing to implement a population health approach for federal clients.</p> |
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The federal government also must play a lead role in reducing the stigma associated with mental health among its specific client groups. The Committee recommends:

⁵ For this summary, the order of the recommendations in this chapter was changed slightly with the first six recommendations drawn from the end of the chapter in the full report.

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| 88 | That the federal government immediately develop and implement an anti-stigma campaign for all federal client groups. |
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Within the overall federal strategy, discharging the coordinated role of federal ombudsman for specific issues relating to mental health will require positions already established within individual departments to be connected with additional ones recommended by the Committee to provide objective oversight of mental health policies, programs and activities in all federal departments and agencies. The Committee recommends:

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| 89 | That the federal government establish a central coordinating mechanism for the development and delivery of mental health policies, programs, and activities across its departments and agencies;
That this federal body work with the Correctional Investigator, the Canadian Forces Ombudsman, and the RCMP External Review Committee and other similar entities to be established by departments to ensure that the needs of individual client groups are being addressed;
That this federal body coordinate and monitor the work of these individual entities in investigating and getting responses to concerns about mental health services for each federal client group;
That this federal body provide an annual report to Parliament. |
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There is no coherent reporting on and assessment of the wide range of insurance plans available to cover federal clients. The Committee therefore recommends:

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| 90 | That the federal government immediately undertake an assessment of all of its insurance plans for all federal clients to determine their applicability and effectiveness;
That this assessment include a comparative evaluation of benefits, of coverage for specific mental health, mental illness and addiction needs, of administrative costs, and of results achieved under the various insurance plans;
That this review of insurance plans be reported to Parliament in 2008. |
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A coordinated approach to the reporting from individual departments is necessary to provide Parliament with the comprehensive information needed for legislative and budgetary

decisions affecting clients for whom the federal government carries direct responsibility. The Committee therefore recommends:

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| 91 | <p>That all federal departments with direct program and service responsibility for specific client groups – including First Nations and Inuit, federal offenders, immigrants and refugees, veterans, Canadian Forces, RCMP, and federal public service employees – develop an annual report that includes a description of federal responsibility, federal programs and services, and the extent to which these meet the mental health needs of clients;</p> <p>That this annual report include an annual inventory of their current respective programs and services as well as a three-year comparison;</p> <p>That the inventory include a clear description for each program or service by fiscal year of the criteria for eligibility, of the number of clients served by the program, of the amount of funding allocated and the amount spent, as well as an evaluation of outcomes related to the determinants of mental health;</p> <p>That the inventory be tabled in Parliament annually starting in 2008.</p> |
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FIRST NATIONS AND INUIT

Indian and Northern Affairs Canada offers basic services for First Nations on-reserve and in Inuit communities, including education, income assistance, housing, and prevention of family violence. Health Canada offers community-based mental health care for First Nations on-reserve; non-insured drugs and short-term mental health crisis counseling as well as addiction treatment for eligible First Nations and Inuit people.

Despite departmental efforts to eliminate them, many serious problems continue that have negative effects on mental health: housing and educational inadequacies, lack of infrastructure and employment and inconsistent economic development efforts. Access to necessary services is hindered by administrative and cross-jurisdictional barriers and many needs are not being met. A forum for holding the federal government accountable is needed with respect to the mental health of First Nations and Inuit. The Committee therefore recommends:

69	<p>That the federal government establish a federal entity for First Nations and Inuit clients, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee;</p> <p>That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of First Nations and Inuit;</p> <p>That the person responsible for this entity be, if possible, of aboriginal origin;</p> <p>That this entity provide an annual report to Parliament.</p>
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Although the federal government has pledged to develop comprehensive reporting based on distinct health indicators for each Aboriginal group, the Committee is concerned that the full information necessary for Parliament and departments to make informed decisions over the next five years will still not be available. Therefore, the Committee recommends:

70	<p>That Indian and Northern Affairs Canada, Health Canada and any other departments with direct program and service responsibility for First Nations and Inuit clients develop an annual inventory of their respective programs and services currently and for the last five years.</p> <p>That the inventory include a clear description of: each program or service by fiscal year; the criteria for eligibility; the number of First Nations and Inuit clients respectively served by the program by geographical location; the amount of funding allocated and the amount spent; and any evaluation of outcomes related to the determinants of mental health.</p> <p>That the inventory be reported to Parliament annually starting in 2008.</p>
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Most importantly, the current configuration of federal departments with their respective legislative or policy bases is not now promoting positive change for First Nations and Inuit. The Committee recommends that:

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| 71 | <p>That the federal government immediately establish an independent study into the federal provision of programs and services relevant to the overall health of First Nations and Inuit;</p> <p>That this study examine various alternatives for the provision of these services; provide clear assessments of these alternatives; and present a comprehensive report with recommendations to Parliament in 2008.</p> |
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FEDERAL OFFENDERS

For federal offenders, Correctional Service Canada offers: basic mental health nursing assessment at reception centres; admission to treatment centres when necessary and available; general services at regular institutions; and essential services for those in community correctional centres.

Many of these services have been described, however, as inadequate or insufficiently accessible. To achieve equivalent standards of care for mental health for federal offenders within institutions and in post-release settings to those available to the general population, the Committee recommends:

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| 72 | <p>That Correctional Service Canada (CSC) develop and implement standard of care guidelines for mental health to be applied within institutions and in post-release settings that are equivalent to those applied in settings accessed by the general population.</p> <p>That CSC guidelines be based on the collection of statistical information about federal offenders and their mental health disorders and addictions, including prevalence rates for mental health disorders, type of treatment utilized (psychotherapy, medication, etc.), rate of hospitalization, etc.</p> <p>That CSC performance with respect to implementing the guidelines be reviewed annually by an independent external body with mental health expertise such as the Canadian Mental Health Commission (see Chapter 16).</p> <p>That data used for the guidelines be compiled and made available to the public and that the raw data be made available to researchers for independent analysis.</p> <p>That the performance assessment be reported to Parliament annually starting in 2008.</p> |
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A variety of measures are needed to enhance assessment of the mental health of offenders at the time of their arrival as well as to improve their ongoing treatment and care. The Committee recommends:

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| 73 | <p>That Correctional Service Canada conduct a full clinical assessment by an accredited mental health professional of each offender to determine their mental health and/or addiction treatment needs to be completed no later than seven calendar days after their arrival at a reception centre.</p> <p>That Correctional Service Canada undertake training of correctional officers and other staff immediately following their appointment to enable them to distinguish between a mental health crisis and a security crisis.</p> <p>That Correctional Service Canada make psychotherapy available to offenders, when medically necessary, provided by a psychiatrist, psychologist, clinical social worker or other health care professional who is not responsible for the risk assessment of offenders.</p> <p>That Correctional Service Canada increase the capacity of its existing treatment centres with additional beds as well as additional staff.</p> <p>That Correctional Service Canada immediately implement expanded harm reduction measures in all federal correctional institutions.</p> |
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After their release to the community, Correctional Service Canada must take responsibility to ensure that offenders receive continuity of care. The Committee recommends:

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| 74 | <p>That Correctional Services Canada establish a case management system that ensures that offenders have access to appropriate mental health treatment upon their release, including a requirement to supply, without cost, enough medication to last until their transition to provincially or territorially provided community-based care.</p> |
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CANADIAN FORCES

National Defence provides non-emergency, outpatient mental health through base clinics, health care centres and support units; specialized mental health services (purchased from provinces); and referrals to operational trauma and stress support centres. Concerns include recruiting sufficient trained professionals and whether revealing a mental illness might lead to the termination of a person's military career.

Many new mental health programs and services have been initiated and should now be evaluated. The Committee recommends:

75	<p>That National Defence develop an annual inventory of its programs and services for mental health;</p> <p>That the inventory include a clear description of each program or service with number of clients served, the amount of funding allocated and spent, and any evaluation of outcomes achieved;</p> <p>That the inventory be reported to Parliament annually starting in 2008.</p>
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More work can be done by the department to enhance the existing peer support network and to address the needs of both members and their families facing operational stress injuries and the resulting symptoms. The Committee recommends:

76	<p>That National Defence require that all medical personnel receive mandatory training with respect to operational stress injury and that this training include:</p> <ul style="list-style-type: none"> • proper recording of military and trauma histories; • methods to recognize/detect symptoms of operational stress injury; • understanding of multiple treatment modalities; and • appropriate long-term follow-up processes; <p>That National Defence make the information available to National Defence and civilian medical personnel through publications, seminars, or other public forums;</p> <p>That National Defence explore measures to encourage more widespread use of peer counselling and increased engagement of family and community.</p>
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Reservists who work with National Defence need sufficient time for their orderly transition from regular to reserve units, and to ensure adequate medical assessments including proper evaluation of the potential for operational stress injury. The Committee recommends:

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| 77 | That National Defence evaluate and report to Parliament on the programs and services currently available to Reservists for mental health problems resulting from their duties while mobilized, including services for post-traumatic stress disorder and addictions. |
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VETERANS

Veterans with mental health concerns constitute a diverse group needing a range of programs. Veterans Affairs Canada provides community-based mental health care services extending beyond those provided under provincial and/or territorial plans; institutional mental health care in Ste-Anne-de-Bellevue, Quebec, and in contract hospitals in other provinces; shared services with DND on operational trauma and stress.

Parliament may not be aware of the full extent of federal efforts to assist disabled veterans in their transition to civilian life and to provide them a high quality of life. The Committee therefore recommends:

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| 78 | That Veterans Affairs Canada in conjunction with National Defence prepare an annual inventory of programs and services for mental health, including the number of clients served, the funding allocated and spent, and the outcomes achieved.
That the report be tabled in Parliament annually starting in 2008. |
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There is merit in having an independent and objective body to review and make recommendations related to the concerns of veterans. The Committee recommends:

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| 79 | That the Government of Canada establish an entity for veterans, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee;
That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of veterans;
That this entity provide an annual report to Parliament. |
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ROYAL CANADIAN MOUNTED POLICE

The RCMP authorizes the use of provincial services as required and offers general health services within regional divisions to ensure its members' fitness to perform their duties. The concerns of RCMP members relate to workload, training, family support and stress management as well as issues relating to pensions and discharge. For RCMP members, counselling after a traumatic situation, assistance with transition to civilian life on discharge, and training to deal with the public as well as mental illness within their ranks are all imperative. The Committee recommends:

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| 80 | <p>That the federal government fund a mental health and addictions training program aimed at RCMP members.</p> <p>That the RCMP make public as soon as possible in 2006 the results of the ongoing analysis by the RCMP task force looking at RCMP disability and the need for programs and services.</p> <p>That the RCMP establish the use of peer counselling for RCMP members following the DND/VAC model for post-traumatic stress.</p> <p>That the RCMP include these initiatives and other programs and services in an annual inventory on programs and services for RCMP officers.</p> <p>That the inventory be reported to Parliament annually starting in 2008.</p> |
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The existing External Review Committee is well-placed to conduct more analysis of the mental health needs of RCMP members. The Committee recommends:

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| 81 | <p>That the RCMP External Review Committee do an analysis of the mental health needs of RCMP members and RCMP veterans and report to Parliament by 2008.</p> |
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IMMIGRANTS AND REFUGEES

Individuals who enter Canada as immigrants and refugees are a heterogeneous group, whose needs are diverse and require culturally appropriate care. After admission, Citizenship and Immigration Canada covers essential and emergency mental health services for those who are unable to pay for them privately.

An external body is needed to provide oversight and to assess how well the federal government meets its commitments to immigrants and refugees. Thus, the Committee recommends:

82	<p>That the federal government establish an entity for immigrants and refugees, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee;</p> <p>That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of immigrants and refugees;</p> <p>That this entity provide an annual report to Parliament.</p>
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Providing mental health programs and services in the client’s language is vital to successful integration and the positive mental health of immigrants and refugees. The Committee recommends:

83	<p>That Citizenship and Immigration Canada provide an annual inventory to Parliament on its programs and services relevant to mental health, including clients served, expenditures allocated and spent, and outcomes achieved, starting in 2008.</p> <p>That Citizenship and Immigration Canada increase funding for and access to language training by diverse groups through increased training allowances, appropriate scheduling of instructional hours, and the location of classes in places that facilitate access.</p>
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FEDERAL PUBLIC SERVICE EMPLOYEES

Treasury Board, the employer of the federal public service, is responsible for labour relations, pensions and benefits, as well as employee and military compensation. It provides coverage of services and benefits that are not provided through provincial or territorial insurance plans; it also offers employee assistance counseling for an estimated 450,000 employees.

Federal public servants work in diverse jobs across the country and face increased stress and limited support at their workplaces. The federal government, as employer, would benefit from establishing relationships with other employers to develop better practices for its own workplaces, in particular, elimination of the stigma associated with mental illness. The Committee therefore recommends:

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- 84 **That the federal government draw upon the model established by the Global Business and Economic Roundtable on Addiction and Mental Illness in coordinating interdepartmental mental health policies, programs and activities for employees.**
- That the federal government, as an employer, form a partnership with other sectors and jurisdictions, including the Global Business and Economic Roundtable on Addiction and Mental Health, to stimulate and facilitate the exchange of best practices in the support of workplace wellbeing and better employee mental health.**
- That, as it develops strategies to support mental health in its workforce, the federal government place a specific emphasis on measures that will reduce and eventually eliminate the stigma attached to mental illness.**

It is essential to evaluate programs regularly to see whether they are meeting their objectives and satisfying real needs. Accordingly, the Committee recommends:

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- 85 **That the Public Service Human Resources Management Agency conduct annual evaluations of the federal government’s provision of policies, programs, and activities designed to support mental health in the public service;**
- That these evaluations be based on clear performance indicators that include the use of surveys to assess employee satisfaction;**
- That the evaluations be used as a basis for adjustments to policies, programs, and activities in order to better suit them to the needs of employees;**
- That results of these evaluations, and the adjustments that were made based upon them, be reported to Parliament on an annual basis starting in 2008.**

CHAPTER 14: ABORIGINAL PEOPLES OF CANADA

Aboriginal peoples are not a single homogeneous unit. First Nations, Inuit and Métis have a pressing need for a wellness and healing strategy that is inclusive of all Aboriginal groups – Indian (status and non-status), Métis and Inuit – from all regions of Canada. Appropriate approaches must be designed to meet the specific needs of each particular group for mental health programs and services, approaches that reflect the recurring call by Aboriginal peoples for community authority and control, cultural accommodation, and equity of access.

Ongoing national mechanisms are required to obtain the advice of Aboriginal peoples and to translate it into action. One of the non-governmental members of the governing Board of the proposed Mental Health Commission must be of Aboriginal origin and one of its two advisory committees must be an Aboriginal Advisory Committee. The Committee emphasizes the recommendation made in Chapter 16 that:

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| 92 | That the Canadian Mental Health Commission (see Chapter 16) establish an Aboriginal Advisory Committee comprised of representatives of Aboriginal communities, whose membership shall be determined by the Commission in consultation with Aboriginal organizations, and shall provide representation from First Nations, Inuit and Métis and broadly reflect the geographic distribution of Aboriginal communities across the country. |
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This Aboriginal Advisory Committee is expected to be a vital contributor to the larger (and longer-term) endeavour – developing a specific wellness and healing strategy for Aboriginal people. The Committee recommends:

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| 93 | That, as a priority, the Canadian Mental Health Commission (see Chapter 16), with the full involvement of its Aboriginal advisory committee, develop a strategy for mental health wellness and healing among Aboriginal peoples.
That the strategy set goals, including a timetable for implementation, and recommend ways to evaluate outcomes.
That the strategy adopt distinct approaches for First Nations, Inuit and Métis |
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The factors that promote wellness in Aboriginal peoples – family and community support, economic opportunities, social and physical security, etc. – are, in their absence, the same factors that create the need for healing. The Committee recommends:

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| 94 | <p>That the Canadian Mental Health Commission (see Chapter 16), in consultation with its Aboriginal advisory committee, develop, as an integral component of the wellness and healing strategy for mental health, a plan that would:</p> <ul style="list-style-type: none">• identify key health determinants;• assess the influence of these determinants on mental health;• detail measures for implementation; and• establish timelines and funding levels needed to promote wellness and healing. |
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An unprecedented level both of federal leadership and intergovernmental collaboration is necessary to address the epidemic of mental health problems, including suicide and addictions, in Aboriginal communities.

If any strategy and action plan is to be successfully implemented, the current jurisdictional ambivalence must be replaced with clear statements of where specific responsibilities lie. The Committee recommends, therefore:

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| 95 | <p>That the Government of Canada create an interdepartmental committee composed of deputy ministers in departments with responsibility for Aboriginal peoples, chaired by the Privy Council Office.</p> <p>That the interdepartmental committee prepare a report to be tabled in Parliament every two years on the impact of the work of these departments on the wellness of Aboriginal peoples, including but not limited to their mental wellness.</p> <p>That this Aboriginal wellness report include an inventory of all federal programs and services specific to each group of Aboriginal peoples, with information on spending and the impact on actual health outcomes achieved, including but not limited to mental health outcomes.</p> <p>That the interdepartmental committee support working groups composed of First Nations, Inuit and Métis representatives to provide information, advice and verification of the report.</p> |
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The goal is a seamless system to promote well-being, not only for First Nations and Inuit, but for all Aboriginal people. The federal government is not required to deliver all the programs and services, but it must accept full responsibility for ensuring their provision. Regardless of who delivers programs and services, the key is to have clear lines of authority and to monitor outcomes carefully. The Committee recommends:

96	<p>That the Government of Canada work closely with the provinces/territories and representatives from the different Aboriginal communities to develop programs and services deemed necessary by Aboriginal peoples.</p> <p>That criteria for the design and delivery of identified programs and services take into account the importance of enhancing community involvement, and of ensuring cultural accommodation and equity of access.</p> <p>That any delivery mechanism for these programs and services include ongoing oversight and public evaluation of outcomes by the funding body.</p> <p>That the criteria for funding and accountability provisions be made public.</p>
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The Aboriginal Healing Foundation has addressed the legacy of abuse and the intergenerational and other impacts of social, psychological, cultural and spiritual injuries. The Committee recommends:

97	<p>That the Government of Canada renew the mandate of the Aboriginal Healing Foundation and provide funding for another three years.</p> <p>That, on a priority basis, the Canadian Mental Health Commission (see Chapter 16) and its Aboriginal advisory committee undertake an evaluation of the efficiency and effectiveness of the Aboriginal Healing Foundation.</p> <p>That the results of the assessment include recommendations concerning the future of the Aboriginal Healing Foundation and be made public.</p>
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A special effort must be made to increase the number of Aboriginal people pursuing careers in the mental health field. Culturally sensitive approaches to train and retain Aboriginal psychiatrists, psychologists, mental health nurses, social workers and others are needed urgently. The Committee recommends:

98	<p>That the Government of Canada work with the provinces and with universities and colleges to establish clear targets for Aboriginal health human resources.</p> <p>That the Government of Canada finance specific access for Aboriginal students seeking careers in mental health.</p> <p>That the Government of Canada increase its financial and social support for Aboriginal students engaged in these studies.</p>
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The proposed Canadian Mental Health Commission has a role in helping to develop consistent standards and protocols, in understanding risk factors and in organizing a national suicide research agenda. Given the clear and immediate need for culturally appropriate actions, the Committee recommends:

99	<p>That the Canadian Mental Health Commission (see Chapter 16), as a high priority, identify measures to reduce the alarming suicide rates amongst Aboriginal peoples.</p> <p>That identification of these measures be a component of its priority action on an Aboriginal wellness and healing strategy.</p> <p>That the Government of Canada allocate a designated suicide fund that accommodates the distinct needs of each group of Aboriginal peoples.</p> <p>That the fund include specific allocations for implementing any measures identified by the Canadian Mental Health Commission as well as for increased research by the Canadian Institutes of Health Research and for specific data collection by the Canadian Institute for Health Information in collaboration with the National Aboriginal Health Organization.</p>
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The relationship between alcohol and other substance abuse, suicide, and other social problems, requires a coordinated population health approach and careful evaluation of what works best to achieve positive outcomes. The Committee recommends:

100	<p>That the Canadian Mental Health Commission (see Chapter 16) identify measures to reduce the alarming alcohol and substance addiction rates amongst Aboriginal peoples.</p>
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That identification of these measures be a component of its priority action on an Aboriginal wellness and healing strategy.

That the Government of Canada allocate a designated fund for addiction that accommodates the distinct needs of each group of Aboriginal peoples.

That the fund include specific allocations for implementing any measures identified by the Canadian Mental Health Commission as well as for increased research by the Canadian Institutes of Health Research and for specific data collection by the Canadian Centre for Substance Abuse in collaboration with the National Aboriginal Health Organization.

Without a clear, complete and accurate picture of the current situation facing Indian, Inuit and Métis populations, it will be extremely difficult to set standards and targets and provide the required resources for programs and services that will be effective in improving the overall wellness of Aboriginal peoples. The Committee recommends:

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| 101 | <p>That the Government of Canada work with the National Aboriginal Health Organization to assess the appropriateness of the First Nations regional health survey for use as a model for data collection for other Aboriginal peoples.</p> <p>That the Canadian Institute for Health Information be encouraged to provide analysis of health determinants data related to each of the Aboriginal peoples.</p> <p>That the Canadian Mental Health Commission (see chapter 16) work with the Canadian Institute for Health Information to improve understanding of mental health causes and outcomes.</p> |
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Alleviating long-term suffering will require long-term funding. Aboriginal peoples have endured a lengthy period of alternating indifference and piecemeal attention from the federal and other governments entrusted with their well-being. The Committee further recommends:

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| 102 | <p>That the Government of Canada undertake immediate analyses of the current level of federal funding for Aboriginal peoples.</p> <p>That the analyses assess how much funding would be required to change key health determinants for Aboriginal peoples.</p> <p>That the analyses include a short, medium and long range assessment for funding needs.</p> |
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That the first report to Parliament by the inter-departmental committee recommended in section 14.6.3 include the results of the analyses.

CHAPTER 15:

MENTAL HEALTH PROMOTION AND ILLNESS PREVENTION

During its hearings, the Committee heard from a number of witnesses who called for greater efforts in mental health promotion and illness prevention.

Broadly speaking, mental health promotion emphasizes positive mental health, as opposed to the treatment of mental illness. It addresses the determinants of mental health – the many personal, social, economic and environmental factors that are thought to contribute to mental health. This approach focuses on improving the health of the population by addressing those determinants of health that are amenable to change, recognizing that doing so is a long-term process yielding results beyond the usual political or even research horizon.

Mental illness prevention, on the other hand, focuses on reducing risk factors associated with mental illness and enhancing protective factors that inhibit its onset or shorten its duration. Risk factors are those that increase the probability of the onset, degree of severity, and duration of major mental health problems. Protective factors are those that improve people’s resistance to risk factors and, therefore, to mental illnesses.

Successful mental health promotion and illness prevention interventions are those based on sound evidence. They also require substantial investments together with the cooperation of different levels of government, service providers, non-government organizations and the individuals affected.

The federal/provincial/territorial initiative known as the Integrated Pan-Canadian Healthy Living Strategy aims to improve the overall health of Canadians by addressing preventable risk factors. While the initial emphasis of the Strategy is on physical activity and healthy eating and their relationship to healthy weight, the Committee believes that the approach should be expanded to include mental health as a priority health issue; it recommends therefore:

103	That mental health be included as an immediate priority health issue in the Integrated Pan-Canadian Healthy Living Strategy.
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In its submission to the Committee, the Canadian Psychological Association suggested that a Canadian Mental Health Guide be created. Modelled on Canada’s Food Guide, it would help to reduce stigma and discrimination by giving concrete advice on mental health topics. The Committee sees merit in this proposal and therefore recommends:

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| 104 | That the Public Health Agency of Canada, in collaboration with other stakeholders, prepare a Mental Health Guide for Canadians and ensure its broad distribution. |
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Health Canada and the Public Health Agency of Canada are both centrally involved in health promotion and illness prevention. Other institutions are also involved in activities related to health promotion, including the Institute of Population and Public Health within the Canadian Institutes of Health Research (CIHR), the Institute of Neurosciences, Mental Health and Addiction, and the Canadian Institute for Health Information (CIHI). As well, Statistics Canada collects and disseminates statistics on the health of Canadians.

Nevertheless, the Committee believes that the federal government should increase its capacity to identify national priorities for mental health promotion and illness prevention, and to translate these priorities into action. Given the overlap between mental health promotion and general health promotion, the Public Health Agency of Canada should continue to be the focal point for mental health promotion.

To complement the work of the Public Health Agency of Canada, the proposed Canadian Mental Health Commission, as outlined in Chapter 16, will include a Knowledge Exchange Centre that works with existing agencies to foster the collection of data relevant to mental health and illness and the exchange of information. The Committee therefore recommends:

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| 105 | That the federal government commit sufficient resources to enable the Public Health Agency of Canada to take the lead role in identifying national priorities for interventions in the areas of mental health promotion and mental illness prevention and to work, in collaboration with other stakeholders, toward translating these priorities into action. |
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That all mental health promotion and mental illness prevention initiatives contain provisions for monitoring and evaluating their impact.

That the Knowledge Exchange Centre (see Chapter 16) work closely with existing bodies such as the Canadian Institute for Health Information, Statistics Canada and the Canadian Institutes of Health Research to collect and disseminate data on evaluations of mental health promotion and mental illness prevention interventions, including campaigns to prevent suicide.

That, in this context, the Canadian Mental Health Commission (see Chapter 16) explore the possibility of:

- **developing common measures to evaluate mental health promotion and mental illness prevention interventions;**
- **analyzing federal policy initiatives for their probable mental health impact;**
- **identifying clusters of problems and/or at-risk populations that are not currently being addressed.**

The Committee has identified suicide prevention as another priority. Although suicidal behaviour is not itself a mental illness, it is highly correlated with mental illness and addiction. Available evidence indicates that when communities work together to increase awareness, the suicide rate can indeed be reduced.

Although many provinces, territories and communities have developed suicide prevention programs, Canada does not have a national suicide prevention strategy. Many, including the Committee, believe the federal government should work with the provinces, territories, and relevant stakeholders to develop one.

In October 2004, the Canadian Association for Suicide Prevention published a *Blueprint for a Canadian National Suicide Prevention Strategy*. It sets out a number of goals, including:

- Promote awareness in every part of Canada that suicide is our problem and is preventable;
- Develop broad-based support for suicide prevention and intervention;
- Develop and implement a strategy to reduce stigma, to be associated with all suicide prevention, intervention and bereavement activities; and
- Develop, implement and sustain community-based suicide prevention programs, respecting diversity and culture at local, regional, and provincial/ territorial levels.

The Committee believes there is merit in advancing the Canadian Association for Suicide Prevention’s initiative to develop a national prevention strategy. The Committee therefore recommends:

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| 106 | <p>That the federal government support the efforts of the Canadian Association for Suicide Prevention and other organizations working to develop a national suicide prevention strategy.</p> <p>That the Canadian Mental Health Commission (see Chapter 16) work closely with all stakeholders to, among other things:</p> |
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- **develop consistent standards and protocols for collecting information on suicide deaths, non-fatal attempts and ideation;**
- **increase the study and reporting of risk factors, warning signs and protective factors for individuals, families, communities and society;**
- **support the development of a national suicide research agenda along the lines proposed by the Canadian Institutes of Health Research.**

CHAPTER 16:

NATIONAL MENTAL HEALTH INITIATIVES

From the very beginning of its study of mental health, mental illness and addiction, the Committee has heard the call for a national mental health strategy. It has recognized that mental health, mental illness and addiction issues resonate with every level of government and that strategies are required at every level – locally, regionally, provincially, federally, and nationally.

The Committee believes it important to emphasize the significant distinction between ‘national’ and ‘federal,’ and to be clear on what a feasible ‘national’ mental health strategy could look like in Canada. While there is a leadership role for the federal government in the development of a national approach to mental health, for a variety of reasons it cannot be up to this level of government alone or even primarily to develop and enforce such a strategy.

It is therefore clear to the Committee that a ‘mechanism’ of some sort is needed to undertake certain critical tasks at a ‘national’ level, to maintain the needed ‘national’ focus on mental health issues and to assist in the development of a national mental health strategy.

The Committee’s key recommendation to achieve this objective, a proposal to create a Canadian Mental Health Commission, was made public by the then Minister of Health, the Honourable Ujjal Dosanjh, on November 24, 2005. This announcement represented the culmination of several months of consultation between the Committee and many mental health stakeholders across the country, including provincial and territorial governments. It was greeted with universal enthusiasm by those concerned with mental health issues in Canada.

The Committee’s intention is that the work of the Canadian Mental Health Commission complement that being done by people and existing structures at the federal, provincial and territorial levels. Among the key principles are that the Commission:

- Be an independent not-for-profit organization at arm’s-length both from governments and all existing mental health “stakeholder organizations”;
- Make those living with mental illness, and their families, the central focus of its activities.

Key elements in the mission of the Commission are:

- To act as a facilitator, enabler and supporter of a national approach to mental health issues;
- To be a catalyst for reform of mental health policies and improvements in service delivery;

- To educate all Canadians about mental health and increase mental health literacy among them, particularly among those who are in leadership roles such as employers, members of the health professions, teachers etc.;
- To diminish the stigma and discrimination faced by Canadians living with a mental illness, and their families.

The Commission will form collaborative relationships with all stakeholders and will also establish a number of advisory committees. The Commission will also create a national Knowledge Exchange Centre and will oversee a 10-year national anti-stigma campaign.

The Commission will be established under federal legislation or other appropriate authority and be funded by the federal government. The Committee recommends that the Board of the Canadian Mental Health Commission have nineteen members, approximately one third from governments and approximately two thirds without any government affiliation or connection. It is critical that all Board members not see themselves, or be seen, as representative of any of the narrowly-focused interest groups that now constitute integral parts of the current mental health system.

The Committee believes that it is essential to move forward quickly, and recommends:

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| 107 | <p>That a Canadian Mental Health Commission be established and that it become operational by 1 September 2006.</p> <p>That the guiding principles, mandate, method of operation and activities of the Canadian Mental Health Commission be as specified in sections 16.2.2 to 16.2.5 of this report.</p> <p>That the composition of the Board of the Commission and its staff be established as set out in sections 16.2.6 and 16.2.7 of this report.</p> <p>That the Government of Canada provide \$17 million per annum to fund the operation and activities of the Commission; of this amount, \$5 million per annum should be dedicated to a national anti-stigma campaign, \$6 million per annum devoted to the creation of the Knowledge Exchange Centre and \$6 million per annum used to cover the operating costs of the Commission.</p> |
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As noted earlier, the movement toward a community based mental health system has not fully taken root. In many cases, deinstitutionalization has been undertaken without the necessary community supports being in place. Part of the problem has been that it has proven difficult to fund the costs of transition from institutional to community care. To complete this transformation of the mental health care system from its institutional base to one that is predominantly based in the community, a targeted investment by the federal government is needed in the form of a Mental Health Transition Fund (MHTF).

In the Committee's view, the MHTF should have two main components: a Basket of Community Services (BCS) to assist provinces to provide services and supports in

communities to people living with mental illness, and a Mental Health Housing Initiative (MHHI) providing federal funds for the construction of new affordable housing units as well as for rent supplements for people living with a mental illness who could not otherwise afford to do so can rent suitable accommodation at market rates.

Therefore the Committee recommended in Chapter 5:

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| 108 | <p>That the Government of Canada create a Mental Health Transition Fund in order to help accelerate the transition to a system in which the delivery of mental health services and supports is based predominantly in the community.</p> <p>That this Fund be made available to the provinces and territories on a per capita basis, and that the Fund be administered by the Canadian Mental Health Commission that has been agreed to by all Ministers of Health (with the exception of Quebec).</p> <p>That the provinces and territories be eligible to receive funding from the Mental Health Transition Fund for a Basket of Community Services, as long as these projects:</p> <ul style="list-style-type: none">• Would not otherwise have been funded; that is, these projects would represent an increase in provincial or territorial spending on mental health services that is over and above existing spending on services and supports plus an increment equal to the annual percentage increase in overall spending on health;• Contribute to the transition towards a system in which the delivery of mental health services and supports is based predominantly in the community. <p>That, as part of the Mental Health Transition Fund, the Government of Canada create a Mental Health Housing Initiative that will provide funds both for the development of new affordable housing units and for rent supplement programs that subsidize people living with mental illness who would otherwise not be able to rent vacant accommodation at current market rates.</p> <ul style="list-style-type: none">• That, in managing the housing portion of the Mental Health Transition Fund, the Canadian Mental Health Commission should work closely with the Canada Mortgage and Housing Corporation. |
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The Committee believes strongly that the Canadian Mental Health Commission should manage the Mental Health Transition Fund, but it has deliberately left open the specification of programs to be covered under the Basket of Community Services. The services and supports available in each community will depend on many factors that are unique to its

particular history and circumstances. The Committee does not believe it wise to attempt to dictate a uniform model.

The Committee also believes that the fund should be distributed to the provinces and territories on the basis of population. Access to family and community-based health care services, however, is a particular challenge in the Territories where huge obstacles to community-based delivery of mental health services are posed by small populations living across vast and remote regions. The Committee therefore recommends:

109	That the territories receive additional funding from the federal government, over and above their per capita allocation from the Mental Health Transition Fund, in order to assist them in addressing the needs of remote, isolated and non-urban communities.
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The Committee also believes that a similar measure should be considered in the case of Prince Edward Island.

The federal government, stakeholders, and Canadians in general, are entitled to know that funding from the MHTF is being used as intended. The Committee realizes that provinces and territories object to having to report to the federal government or a national organization on how they manage their health care spending. Nonetheless, the Committee strongly believes that there should be some form of accountability for the use of money from the Fund. Therefore the Committee recommends:

110	That the use of the monies from the Mental Health Transition Fund should be subjected to an external audit, to be performed by provincial auditors general in order to ensure that the monies are spent in a manner consistent with the two objectives of the Transition Fund, namely: <ul style="list-style-type: none">(a) to fund community based mental health services and supports; and(b) to increase the total amount each jurisdiction spends on enhancing mental health and treating mental illness.
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There are currently no reliable data on what it would cost to complete the transformation of the whole mental health care system from an institutional base to one that is predominantly based in the community. Consequently, the Committee has relied upon the work of others on a smaller scale to establish a reasonable estimate of the size of an effective transition fund.

The Committee's estimate of the overall cost of transforming the mental health system is based on the work of the Toronto-Peel Mental Health Implementation Task Force. It

concluded that, to achieve an adequate transformation, the Toronto-Peel region's mental health system required an investment of approximately \$245 million over five years. By extrapolation, the total required for Canada would be \$2.148 billion.

The Committee believes that ten years is a realistic time frame for transition and recommends:

111	That the Basket of Community Services component of the Mental Health Transition Fund average \$215 million per year over a ten year period, for a total of \$2.15 billion.
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One of the biggest problems facing people with mental illness is the lack of affordable housing. According to data provided by the Canada Housing and Mortgage Corporation, 15% of the Canadian population as a whole is in need of adequate, suitable, and affordable housing. At the same time, the housing situation confronting people living with mental illness is considerably worse; 27% (approximately 140,000 people) are without adequate, suitable, and affordable housing. The Committee believes that this constitutes discrimination against people living with mental illness.

According to the Canada Mortgage and Housing Corporation approximately 57,000 people living with mental illness would need access to some form of affordable housing in order to bring the proportion of people living with mental illness in need of housing down to the national average.

The needs of people living with mental illness are not all the same – some require supportive services while others who are more independent have trouble finding adequate housing. The Committee therefore concluded unequivocally that: more affordable housing units are required; more assistance is needed so that people can afford to rent existing accommodation at market rates; and more supportive services are needed so that people living with a mental illness can live in their communities.

The Committee believes that a program to meet the core housing needs of people living with mental illness should be based on a 60/40 mix of rent subsidies relative to the construction of new housing units. The Committee also believes that when the Mental Health Housing Initiative is launched, its initial focus should be on rent-subsidized units because of the need to act quickly to address the housing shortage. Moreover, the federal government should pay the full share of rent subsidies for the first three years. Consideration should also be given to innovative approaches by governments, health authorities and non-profit organizations, such as aggregating their subsidies to allow partnerships with tenants in the purchase of housing properties.

The Committee therefore recommends:

- 112 That the Government of Canada invest \$2.24 billion over ten years in the Mental Health Housing Initiative (MHHI) that is to be established as part of the Mental Health Transition Fund.
- That the MHHI have as its goal to reduce the percentage of Canadians living with mental illness in need of housing that is adequate, suitable and affordable from 27% to the national average (15%) of people in need of such housing, specifically by providing 57,000 people living with mental illness with access to affordable housing.
- That, over the life of the MHHI, 60% of its funds be allocated to providing rent supplements to people living with mental illness who would otherwise be unable to afford to rent accommodation at market rates, and the remaining 40% be devoted to the development of new affordable housing units.
- That, in order to provide immediate assistance to as many people as possible, during the first three years of the MHHI, fully 80% of available funds be allocated to rent supplements; and that during this period the federal government pay the full share of the rent subsidies, after which the cost of the rent subsidies be shared according to existing federal-provincial-territorial arrangements.
- That innovative approaches by governments, health authorities and non-profit organizations be supported, such as aggregation of subsidies to allow partnerships with tenants in the purchase of housing properties.
- That, following the ten-year life of the MHHI, the Canada Mortgage and Housing Corporation be mandated to maintain the percentage of people living with mental illness who are in need of housing that is adequate, suitable and affordable at the same percentage as that of the population as a whole.

In addition to the Basket of Community Services and the Mental Health Housing Initiative, the Committee believes there are several other important elements that should be incorporated in the Transition Fund.

Concurrent Disorders. Throughout most of Canada there is no complete, comprehensive set of services and supports to address substance use problems and addictive behaviours. The Committee is convinced that the federal government can and should do more to address substance use problems, addictive behaviour, and particularly concurrent disorders. Specifically, the Committee believes that the federal government should provide an additional \$50 million to focus service reform initiatives addressing concurrent disorders. The Committee therefore recommends:

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| 113 | That the Government of Canada include as part of the Transition Fund \$50 million per year to be provided to the provinces and territories for outreach, treatment, prevention programs and services to people living with concurrent disorders. As with the rest of the Transition Fund, this money would be managed by the Canadian Mental Health Commission, but in respect of this component of the fund there should be close consultation with the Canadian Centre for Substance Abuse, as well as the provinces, territories, and other stakeholders. |
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Telemental Health. As noted previously, telemental health has enormous potential given that the process of psychiatric diagnosis is not primarily a physical one, but relies on verbal and non-verbal communication. The Committee recommended in Chapter 12 that the federal government assist provinces to utilize the savings from reduced transportation and other costs gained from the implementation of telemental health services to fund their operating costs. It recommends that:

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| 114 | That the Government of Canada provide the provinces and territories with \$2.5 million per year to help them move forward with their plans for telemental health. This money would be part of the Mental Health Transition Fund and be administered by the Canadian Mental Health Commission. |
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Peer Support. In Chapter 10, the Committee documented the importance of self-help and peer support for people living with mental illness and their families. Therefore, the Committee recommends:

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| 115 | That the Government of Canada provide the provinces and territories with \$2.5 million per year for peer support and self-help initiatives. This money would be part of the Mental Health Transition Fund and be administered by the Canadian Mental Health Commission. |
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Research. In addition to the various elements of the Transition Fund, the Committee reiterates its support for research leading to meaningful improvement in the lives of people living with mental illness and addiction in Canada. That is why, in Chapter 11, the Committee recommended:

116	<p>That the federal government commit \$25 million per year for research into the clinical, health services and population health aspects of mental health, mental illness and addiction.</p> <p>That these funds be administered by the Canadian Institutes of Health Research (CIHR), through the Institute of Neurosciences, Mental Health and Addiction under the guidance of a multi-stakeholder board and in consultation with the Canadian Mental Health Commission.</p> <p>That this \$25 million be incremental to the funding currently provided to the CIHR.</p>
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The total annual cost of implementing the Committee’s recommendations is outlined in the following table:

Item	Cost (\$ million per year)
Mental Health Commission	17.0
Mental Health Housing Initiative	224.0
Basket of Community Services	215.0
Concurrent Disorders Program	50.0
Telemental health	2.5
Peer support	2.5
Research	25.0
Total	536.0

The Committee has always believed that the responsible course of action is not simply to recommend that the federal government spend more money in a particular area but also to suggest how that money can be raised

The Committee realizes that there is no “best” way of raising the required revenue. After careful consideration, the Committee recommends:

117 **That, in order to raise additional revenue to pay for the recommended federal investments in mental health, mental illness and addiction initiatives, the Government of Canada should raise the excise duty on alcoholic beverages by a nickel a drink, that is by 5 cents a standard drink.**

The revenue raised should be earmarked for spending on mental health, mental illness, and addiction.

One standard drink in Canada is 13.6 g of alcohol – a 12 ounce bottle of beer, a five ounce glass of wine or 1.5 ounces of 80-proof liquor. Five cents a drink translates into 5 cents on a bottle of beer, approximately 25 cents on a bottle of wine and approximately 85 cents on a bottle of spirits.

The Committee believes that this increase in excise duty should not apply to alcoholic beverages with an alcohol content of 4% and lower (light, or other low alcohol beer). In fact, the Committee believes that society would benefit from a shift in consumption from higher to lower alcohol beer. Therefore, the committee recommends:

118 **That the Government of Canada lower the excise duty by 5 cents a drink on beer of alcohol content between 2.5% and 4%, and the excise duty on beer of alcohol content under 2.5% should be eliminated entirely.**

In all, these changes to the federal excise tax on alcohol would raise approximately \$478 million per year. There are a number of ways to bridge the potential shortfall of \$58 million per year between the Committee's recommendations and its proposed source of revenue. These include utilizing funds from general revenue, spreading out the housing costs over a longer period of time or using a portion of the surplus from the mortgage insurance program of the Canada Mortgage and Housing Corporation.

It should be noted that the Committee's revenue-raising proposal is not linked to its expenditure proposal in any causal way. The only connection between the two is that the amount of money is the same. Indeed, the Committee has deliberately avoided making any statements about the nature of a causal link, if any, between mental health and substance use disorders. Rather, the Committee has simply made a recommendation to the government on how to raise the additional revenue necessary to implement its recommendations that is both economically sound and also politically feasible.

EPILOGUE —

THE HUMAN FACE OF A TRANSFORMED SYSTEM

Emmy's story appears as the epilogue to the full report. We reproduce it here in the hope that readers will always keep in mind that the mental health system is not about governments or programs or politics or service providers. It is about helping people with mental illness to live the best life they possibly can.

EMMY'S STORY

What follows is a true story, a personal history provided to the Committee by Emmy (not her real name), a person affected by a mental illness. Emmy's words and expressions have been changed slightly but it remains her story. It describes how she and her family have been dealt with by the current health care and social services "system" through six episodes of acute illness. Emmy's story "*The Way It Is*" describes how things actually work and don't work for the great majority of Canadians with mental illness.

At the end of Emmy's actual story is another one — a description of how she, her family and the members of this Committee would hope and expect her to be treated in a transformed system "*The Way it Should Be*" reflects what we hope will be created by implementation of the recommendations in this Report.

THE WAY IT IS

I was born and raised in a small town in southeastern Ontario. For the first six years of my life you would have described me as a typical kid in an ordinary family in a town much like hundreds of others throughout Canada.

Age Six

Around the time I started school our life changed. My Dad started to act funny. First he got really moody, then strange and then wild. It was not funny; it was scary. Sometimes he would be OK but suddenly without warning he would do wild things like shout and yell and throw things at Mom and me over nothing at all. Then he got to pushing and shoving and sometimes hitting. You never knew when he would explode or what would set him off. I had no idea what was going on except Mom said she thought Dad was sick. I didn't want Dad to be sick. I just wanted him back the way he was. I worried about him and us all the time.

Mom was worried too and ashamed to show her face as Dad's weird behaviour became obvious to people in the neighbourhood. She didn't know what to do; she didn't know anybody to call on for help or even advice. Dad got worse and worse. Finally one day he got so violent that Mom called the police. They came to the house and took him away. We hated to think what the neighbours thought about that! Mom was really too embarrassed to talk to

any of them for quite a while. She told me never to tell anybody that there was anything wrong with Dad, like he was sick or anything — just that he had gone away.

After a couple of days the police told Mom that Dad really was sick — sick in the head. They told her they had taken him to a hospital in the city, 30 miles away, where there were people to look after him and doctors who could help him.

I always wondered if it was my fault. Did I do something wrong that set Dad off and made him sick?

For the next few years Mom and I kept to ourselves most of the time. Dad was in and out of hospital — more in than out — and couldn't hold a job. When he was home, he would act fairly normal for a while but then he would fly off again and Mom would have to get him back to the hospital. Not really knowing what was wrong with him, trying to keep quiet about it all, and not being able to help him get better really made Mom and me confused and frustrated. We were always short of money too. During the times when he felt more like his old self I'm sure Dad blamed himself for not bringing in an income to help support the family; thinking about that probably made him sicker.

Mom was really tired — working full time, looking after me (and Dad when he was home) and taking the bus up to the city as often as she could on weekends when he was in hospital.

Age Fifteen

I know that Mom really worried about me as a teenager, especially about the time I turned 15 when, without realizing it, I started to get really moody. Then, just like Dad, I started to do weird things. Mom was at her wits end and both of us were really scared. I didn't know what was happening. It seemed like I was alone in the world; there was nobody to help me, not even Mom. I didn't know how to stop feeling and acting the way I was. It seemed like some strange powerful force was inside my head making me behave badly and do wild, violent things I really didn't want to do.

Mom didn't know what to do. I think she figured I was going through a phase and would grow out of it. She might have thought about taking me to the hospital in the city, like Dad, but she didn't do it or even talk to me about it.

In the meantime my school work was going down the tubes. I just couldn't pay attention to what was going on, so lots of days I would just skip and stay home in my room with the door shut, doing nothing. Then I dropped out of school altogether. I got a part-time job but I couldn't pay attention to the work I was supposed to do and after a few weeks they fired me. I got another job but lost that one too. I got job after job but I always wound up getting fired a little while later. After a few months of that I gave up trying to work. I just sat at home all the time and watched TV. I hardly ever saw anybody except Mom when she got home from work but we didn't talk much. Neither of us knew what to say, what was the matter with me or what to do.

Slowly life went on. After a long time my symptoms gradually diminished, I was able to concentrate better and I went out and got a job that I was able to keep.

Age Twenty-Three

I figured Mom had enough to do looking after Dad so when I was in my twenties I got an apartment and struck out on my own. That was great until about a year later when I began to get symptoms again. Mom noticed them coming on before I did and began to worry. Soon they were obvious even to my neighbours who also worried about me.

I didn't leave my apartment for days on end. When I didn't show up for work I got fired. I soon ran out of money and couldn't pay my bills. Mom tried to persuade me to go to the doctor but I kept putting it off until one night when I was really loud and wild one of the neighbours called the police. They came to the apartment and took me to the local acute-care (Schedule 1) hospital where I was admitted and stayed there for a week or so. Then they transferred me to the same psychiatric hospital in the city where Dad was still being treated from time to time. With treatment there, my symptoms got better, but very slowly. Eventually I was released and came back to my home town where I got another job, a new apartment and re-learned how to cope on my own.

Age Thirty-Four

I was reasonably OK for about ten years. But then my symptoms returned — I had another relapse! First I lost my job and then my apartment. I cut off contact with everybody and in my wild state it was not long before the police caught me shoplifting and creating a disturbance in a store. Happily the police recognized me as someone who was sick. Instead of putting me in jail they took me to the Schedule 1 hospital for treatment.

Over the next couple of years I was in and out of hospital, just like Dad, staying for weeks or months at a time. When I was in hospital and being treated, my symptoms gradually came under control; when I felt better they let me go. I was usually able to find another place to live but because I didn't have much money it was usually pretty tacky and in a tough part of town where not feeling safe made me anxious. Without anybody in the community to help me on a regular basis it was hard to cope with the stresses of everyday living and my illness returned — always too fast.

After returning to my home town a couple of times, when I got out of the psychiatric hospital I decided to stay in the city near the hospital to have easier access to the follow-up services they provide. Once in a while I went to the city's drop in centre but it was hard to get to know anybody; they were always coming and going and I didn't make any friends. When my symptoms got really bad I would go to the hospital's emergency room where they knew me. They would arrange for my re-admission to hospital and we would start all over again.

After a few times in and out, however, I recovered again. My symptoms disappeared and when I began to feel much better I decided to leave the city and get an apartment back in my hometown to be closer to my family and where I knew more people.

Age Thirty-Eight

It was great for a while. But before long the old problem started up again — another relapse. Mom was the first to notice. She was a great help all along but she was showing her age by then. She had a tough time looking after Dad and keeping her eye on me too. I couldn't seem to get on the same wavelength with any of my friends and without being able to get to the drop in centre in the city I was really isolated. I stayed alone in the apartment most of the time. The only person in town I could turn to was my family doctor but all he could do is monitor my meds. He just didn't have the time to give me more support than that. But one day I was so bad when I showed up in his office that he called an ambulance and sent me to the city and the psychiatric hospital. I was there for weeks until I finally got back on an even keel. They let me come back home but with nobody in town to help me on a regular basis so it wasn't very long until I was back in the hospital again. This continued off and on for a long time, as often as once a year but sometimes only once every couple or three years. It was not much of a life. The few friends I had left drifted away, one by one, and when Dad and then Mom died, I was really alone.

Age Sixty-Six

Shortly after Mom died I relapsed again and this time my symptoms were really bad; I was really out of it! I didn't feel well in other ways too so the doctors at the psychiatric hospital had some other doctors examine me. They found out that I had developed other medical problems in addition to my mental illness. They gave me more pills to take and, after many weeks, I began to feel better. But this time they said I couldn't go back home. They told me I would have to live in a nursing home near the hospital where I could get my meals regularly and where there were people all the time to look after me. It sounded good but it turned out that everybody else there was a lot older and sicker than I was. A lot of them couldn't even get out of bed and those who could just sat in the hall most of the time by the desk. There was nobody for me to talk to and nothing to do but watch T.V. or sit in the hall with the rest. After a while I realized that I would never leave. I would stay in that place until the day I died.

THE WAY IT SHOULD BE

Age Six

When Dad's strange behaviour started to affect us all, Mom got him to go with her to the family health centre where they met with a counsellor. She arranged for Dad to be seen by a doctor who told them that he was suffering from a mental illness; he arranged for Dad to be seen by a psychiatrist, a specialist from a city hospital about 30 miles away who came to our town from time to time to help family doctors provide their patients with the most effective on-going care and treatment. The counsellor sat down with Mom and me, explained the nature of Dad's illness and helped us understand what was wrong with him and what he was going through. She gave Mom some information to read and arranged for her to join a training and support group made up of the family members of people affected by the same kind of mental illness that Dad had. As we learned more about the disease and its effects, both Mom and I became much more comfortable talking about Dad's illness with our neighbours and others, including my classmates and friends. We were able to cope much

better with his periods of erratic behaviour that, even with his medication and treatment, still affected him from time to time.

Age Fifteen

As soon as Mom began to notice my mood swings she talked me into going with her to the family health centre where we saw the counsellor again. I also saw the doctor who referred me to a psychiatrist right away who told me that I was suffering from the same kind of mental illness that Dad had. She prescribed some medication that helped me control my moods and behaviour. With the symptoms under better control I was able to concentrate. I stayed in school and, with the counsellor's help with day-to-day problems, I did OK. I also joined a support group made up of other kids my age who were also coping with illnesses of one kind or another, most of them mental, like mine. My friends stuck by me; they knew I was sick, not weird!

Age Twenty-Three

Mom and Dad (who was much better then) talked with me about what they saw going on. They persuaded me to go to the family health centre to see the same doctor who had been monitoring my medication ever since I first got sick. He arranged for my admission to the local acute-care (Schedule 1) hospital for a short stay during which a psychiatrist from the city adjusted my medication. I also went every day to an educational program where I learned new skills to cope with my symptoms better. They didn't go away completely but my condition improved fairly quickly.

When I got out of hospital I was referred to the town's satellite office of a provincial mental health program where I established regular contact with a case manager who helped me apply for a disability (ODSP) allowance. I continued to see the psychiatrist on her regular visits to town. My case manager also arranged a regular ride to the city for me where I went to a skills training program twice a week. I got a new apartment and, after a while, with the help of an employment support worker I got a part-time job in town to supplement my ODSP cheque.

Age Thirty-Four

After the police took me to the hospital, I was only there for a short period until my symptoms stabilized. The hospital arranged for my case considered by the Court Diversion program and re-connected me with my case manager; no criminal charges were laid. My psychiatrist and the psychiatric hospital team in the city decided I would benefit from a referral to an Assertive Community Treatment (ACT) Team there. They arranged for me to move into supportive housing right there in the city where I had ready access to the outreach services of the Team and hospital and still be only a short bus ride away from my family and friends in my home town.

My symptoms stayed under pretty good control. I continued to live in the city. A little while after I recovered from my last episode I volunteered to work in a consumer initiative program. The rules had been changed so I was able to retain my OSDP benefits while working as a volunteer I did such a good job, before very long I was offered a position as a

member of the staff. I continued to work there regularly. Knowing that I was capable of doing useful work to support myself was the best treatment of all for my mental illness. Being independent is a great confidence-booster and when I am confident I can cope very well with my illness.

After a while I decided to leave supportive housing and get my own apartment. I thought about going home but with the encouragement of the ACT Team I decided to remain in the city where I could enroll, part-time, in the early childhood education program at the college there. It was great to be able to pursue my interest in children and I found out that I was a pretty good teacher. With the ACT Team helping me over the rough spots, I completed the course, and graduated.

I really felt well and, with my diploma in hand, I decided to move back home to be near my family and more of the friends I grew up with. I didn't need the ACT Team any more but they referred me to a case management service in my home town where I could get ongoing support when I needed it.

Age Thirty-Eight

After I got my own apartment, I got in touch with the case management team who worked with me so that I could recognize signs of relapse threatening and seek help right from the start. I also got involved with a consumer support group in town where I was able to meet with a mental health worker whenever I felt a need to talk with somebody about my illness. I had good and bad days, of course, but most of them were good and soon I felt well enough to look for work. It wasn't long before I got a full time job in a daycare where I made enough money to support myself. It felt really good not to have to depend on my disability (OSDP) payments any more.

Age Sixty-Six

It was hard to accept that after so many years of coping so well on my own with only the occasional need for help from my case manager but about this time I realized that my old symptoms were not as easy to overcome as they were a few years ago. I saw my family doctor, mental health worker and case manager and we all agreed that I needed more intensive help than they were able to provide. I was referred to a Geriatric team that worked out and provided the support necessary to help me stay in my own home. I was able to call on them any time I ran into a problem I couldn't deal with alone. I became a member of the seniors centre in town where I kept in touch with my old friends and met a lot of new ones too who were always willing to help me when I needed it. With all that help I was able to stay happily at home in my own apartment for the rest of my life.

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EPILOGUE — THE HUMAN FACE OF A TRANSFORMED SYSTEM

EMMY'S STORY

THE WAY IT IS

THE WAY IT SHOULD BE

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