



Out of the shadows Forever

Annual Report 2008-2009

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Message from the Chair and President & CEO

Michael Kirby & Michael Howlett

In May of 2006, the Senate Social Affairs Committee produced the first ever national report on mental health, *Out of the Shadows at Last*. One of its key recommendations was the creation of the Mental Health Commission of Canada to help bring into being an integrated mental health system that places people living with mental illness at its centre. Less than a year later, the federal government provided funding for the Mental Health Commission of Canada and the first meeting of the Commission's Board took place in Calgary in September of 2007.

The progress that has been made towards achieving the Commission's mandate has been very encouraging. In the short time that we have been operational, the MHCC has set up headquarters in Calgary, with offices in Ottawa and Toronto, and has grown from two to thirty-seven staff members.

A framework has been developed for the Mental Health Strategy for Canada. Public consultations were held in 13 different cities across Canada with participation from a wide cross section of stakeholders. In addition, more than 1,700 people participated in an online survey.

The Commission is undertaking Canada's largest ever research study on mental health and homelessness. Demonstration projects are currently being set up in five different cities, each focusing on a distinct group of homeless people living with mental illness.

Our Anti-stigma/Anti-discrimination Initiative is underway and is the biggest systemic effort to reduce stigma of mental illness in Canadian history.

Both the Knowledge Exchange Centre Initiative and the Commission's volunteer program, Partners for Mental Health, are in the planning stages.

Our eight Advisory Committees are working on 24 different projects in support of the MHCC's primary initiatives.

The theme of this inaugural annual report is *Out of the Shadows Forever*. To realize that vision, there are a number of factors that are crucial to our success. The first is the necessity for the Commission to work closely with partners that have a vested interest in the success of our mission. The Commission can be a catalyst to stimulate change and innovation in the organization and delivery of mental health services and supports, but we cannot do it alone. The MHCC must also create new partnerships and engage a new generation to build a grassroots social movement to ensure that mental health issues stay out of the shadows forever. This report will give you insight into the extent of partnerships involved in the work of the Commission.



Michael Howlett (l), Michael Kirby (r)

Throughout this report, you will read the stories of real people whose lives have been affected by mental illness. A common thread running through these stories is the promise of hope and the possibility of recovery. We look forward to the day when the harmful effects of stigma and discrimination directed at people living with mental illness has been significantly reduced, to the day when we have a truly seamless continuum of care that allows people living with mental disorders to find their individual paths to recovery.

This is a time for leadership, innovation and energy in mental health care across Canada. The passion and commitment that we have witnessed from countless people and organizations over the past 18 months gives us great hope and confidence for the future of the mental health system in Canada.

Thank you to our Board of Directors, Advisory Committees, our dedicated and capable staff, and all of the stakeholder organizations and individuals for your contributions to the progress that the Mental Health Commission of Canada has made to date.


Michael Kirby
MHCC Chair


Michael Howlett
MHCC President & CEO



Candace Watson

Mother & Wife | Nurse | Likes music & sports
CMHA Board Member

My name is Candace Watson. I'm 35 years old and I was diagnosed with bipolar disorder in 1995. Before I was diagnosed, I did well in school, was a high achiever involved in lots of activities including sports and music. I thought I wanted to be a doctor. When I went into university I decided to try the nursing profession as a precursor, just to see if I really wanted to be a doctor.

But in January of 1995, my anxiety got out of control and I started to have panic attacks at school. I'd walk into a class and break down crying. I wasn't managing very well. So that's when I first started to seek help from a counsellor.

I was diagnosed with Bipolar in the spring of 1995 after I stopped sleeping for a couple of months. I ended up having what they call a manic episode. I thought I was God. I thought I could predict the future. I was calling everybody I knew since kindergarten to tell them I loved them. I was just on a super high; I felt invincible.

It's devastating when you are diagnosed with an illness like this. It broke me into a million pieces. I felt like I didn't know right from wrong, real from unreal. That summer I remember asking my parents, "Is this a normal thought or an abnormal thought?" I didn't know anymore. I couldn't trust what my brain was telling me. It was a really difficult time.

I still struggle, but it's so much better because I know the illness and I know myself. I'm able to manage a lot better. I've come up with a mission statement in my life "to bring respect, dignity and help to those suffering with mental illness." And as part of that, I started working as a nurse on two adult psychiatry units at Rockyview Hospital. I'm also sitting on the Board of Directors of the Canadian Mental Health Association. It's been really good for me — a confidence booster. I went through years of low self esteem because of my illness. Now that I have a mission, it's brought focus to my life. I'm not worried about people finding out that I have this illness because I'm quite confident that I am a good person, a functioning person. I have things to offer. I think developing that confidence in yourself is a key factor in being healthy.

My advice to people who are struggling with mental illness is first of all, get your support systems in place. The other is to have confidence in yourself that you're still a normal person even though you have mental illness. You're just as valuable as anybody else.

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I think developing that confidence in yourself is a key factor in being healthy.

Introduction

The Commission's Vision, Mission & Strategies

The MHCC, a non-profit organization with a mandate to focus national attention on mental health, is funded by the federal government, but operates at arm's length from the government.

The Mental Health Commission of Canada (MHCC) was created by the federal government in its budget of March 2007. It grew out of the most extensive consultation on mental illness ever conducted in this country. That consultation process became the basis of a report of a Senate Committee chaired by Senator Michael Kirby called *Out of the Shadows at Last*. It was the first report produced in Canada that viewed mental illness from the perspective of both the total mental health system, and the total health care system in Canada.

The MHCC, a non-profit organization with a mandate to focus national attention on mental health, is funded by the federal government, but operates at arm's length from the government. The Commission has the support of all provincial and territorial governments, except Quebec. The Board of Directors includes 11 non-government members and six members appointed by the federal, provincial and territorial governments.

The goal of the MHCC is to help bring into being an integrated mental health system that places people living with mental illness at its centre. To this end, the Commission encourages cooperation and collaboration among governments, mental health service providers, employers, the scientific and research communities, as well as Canadians living with mental illness, their families and caregivers.

To achieve the Commission's mandate, four major initiatives and one program will be the focus of attention, specifically:

1. Mental Health Strategy for Canada
2. Research Demonstration Project in Mental Health & Homelessness
3. Anti-stigma / Anti-discrimination Initiative
4. Knowledge Exchange Centre Initiative
5. Partners for Mental Health Program

In this, the MHCC's inaugural Annual Report, we are eager to share with Canadians the progress that has been made towards accomplishing our mandate.

Vision

A society that values and promotes mental health and helps people living with mental health problems and mental illness to lead meaningful and productive lives.

Mission

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

A Mental Health Strategy for Canada



Participants in the Toronto consultation

The Mental Health Commission of Canada has been given the responsibility to initiate and guide a process that will result in the first mental health strategy for Canada.

The Mental Health Commission of Canada has been given the responsibility to initiate and guide a process that will result in the first mental health strategy for Canada. A mental health strategy for Canada can serve to focus national attention on mental health issues and provide a roadmap for implementing a truly comprehensive approach to mental health and mental illness.

Such an approach will address the mental health needs of everyone living in Canada and point the way towards a mental health system that assists everyone to achieve the best possible mental health and well-being. In particular, a mental health strategy can greatly contribute to improving the health and social outcomes of people living with mental health problems and illnesses.

The first review of the framework document was undertaken by the MHCC's Consumers' Council, a group of Commission family members who have openly shared their personal experience of mental health problems or illness.

A Two-Phased Approach

Planning for the Commission's efforts to develop a mental health strategy began in earnest in the spring of 2008. The Director of the Mental Health Strategy Initiative, Howard Chodos, Ph.D., and newly-hired Senior Policy Advisor, Gillian Mulvale, Ph.D., met with all the Commission's Advisory Committees. Two clear messages emerged from these meetings. First, that it was important to build on the legacy of the Senate Committee report *Out of the Shadows at Last*, as a foundation to go forward, and second that it was essential that the MHCC move quickly to engage Canadians in the process of developing a mental health strategy.

Based on this feedback, the Strategy Team developed a two-phased plan. The focus of the first phase was to set the overall direction for change by describing WHAT a transformed system for addressing mental health issues should look like; the objective of the second phase would be to work out a blueprint for HOW to go about changing the system. The team concluded that it was essential to begin by building support for a framework that defined WHAT we wanted to achieve so that there could be a coherent approach to tackling the many complex questions that will arise in figuring out HOW to get there.

A number of key principles were adopted to help guide the development of the strategy. First, that the ultimate document must be a "practical" one that assists governments and other stakeholders to address the many challenges associated with improving the mental health and well-being of people living in Canada. Second, it is essential to respect the reality that the organization and delivery of health and social services for the general population in Canada are largely a provincial and territorial responsibility, and the strategy must therefore be adaptable to all the different regions and jurisdictions in the country. Third, the strategy must be inclusive and address all mental health needs. Finally, the development of the strategy must be done collaboratively and build on existing strengths across the country.



MHCC Mental Health Strategy Team – Howard Chodos, Mary Bartram, Gillian Mulvale

Work on the draft framework document to articulate the vision for WHAT a transformed mental health system should look like began in mid-July (by then Mary Bartram, M.Sc., had joined the Strategy Team as its Senior Advisor on Governmental Relations). A draft of that framework document — *Toward Recovery & Well-Being: A Framework for a Mental Health Strategy for Canada* — was circulated to the entire Commission "family" at the end of August.

The first review of the framework document was undertaken by the MHCC's Consumers' Council, a group of Commission family members who have openly shared their personal experience of mental health problems or illness. Additional feedback was solicited from the MHCC Board of Directors and Advisory Committees, as well as from federal, provincial and territorial officials. A revised draft framework document was published in January 2009 — the first document to be released for public discussion by the Mental Health Commission of Canada.

The first regional dialogue was held in St. John's, Newfoundland, on February 2, and by March 31 the team had held 14 meetings in 12 cities, with a final stop in Winnipeg scheduled for early April 2009. What was particularly evident at every meeting was a feeling of excitement among participants, as well as a generous and positive spirit.

WHAT Should a Transformed System for Addressing Mental Health Issues Look Like?

Toward Recovery & Well-Being sets out eight high-level goals that are key to a comprehensive approach to mental health and mental illness in Canada, one that can both foster recovery for people living with mental health problems and illnesses, and promote the mental health and well-being of all people living in Canada. The goals capture, in general terms, the elements that need to be addressed if we are to succeed in transforming how mental health issues are approached. They are designed to be relevant to all people living in Canada and to all mental health contexts. The document suggests that in a transformed system the following elements are integral:

1. The hope of recovery is available to all;
2. Action is taken to promote mental health and well-being and to prevent mental health problems and illnesses;
3. The mental health system is culturally-safe, and responds to the diverse needs of Canadians;
4. The importance of families in promoting recovery and well-being is recognized and their needs are supported;



Participants in the Yellowknife regional dialogue

5. People of all ages have equitable access to a system of appropriate and effective programs, services and supports that are seamlessly integrated around their needs;
6. Actions are based on appropriate evidence, outcomes are measured and research is advanced;
7. Discrimination against people living with mental health problems and illnesses is eliminated, and stigma is not tolerated;
8. A broadly-based social movement keeps mental health issues out of the shadows — forever.

Public Consultations

Immediately following the release of *Toward Recovery & Well-Being*, the Mental Health Strategy Team undertook a two-pronged process of public consultation to gather additional feedback prior to revising and finalizing the document. A series of regional stakeholder dialogues were planned and a parallel online consultation, open to everyone, was initiated.

The first regional dialogue was held in St. John's, Newfoundland, on February 2, and by March 31 the team had held 14 meetings in 12 cities, with a final stop in Winnipeg scheduled for early April 2009. What was particularly evident at every meeting was a feeling of excitement among participants, as well as a generous and positive spirit. Strong support was voiced for the process, which was generally seen as safe and supportive. Many participants came in feeling skeptical about “yet another consultation exercise” but left feeling more hopeful about the possibility of genuine change.

The dialogues were structured to maximize the ability of participants to make concrete suggestions to improve the document, to raise pertinent issues for their regions as well as to furnish the Strategy Team with comparable data across regions. A team of expert facilitators was engaged to assist the Mental Health Strategy Team in conducting the meetings. The meetings were by invitation only and each involved 25 to 35 participants representing a variety of stakeholder groups. The feedback was extremely rich, with participants expressing general support for the direction taken in the document, while also contributing many suggestions for improvement.

Members of the Strategy Team posted a blog following each meeting to allow people across the country to follow the progress of the consultations. In many centres, there was good media interest in the work of the Commission, and the Team met with provincial or territorial officials in almost every city they visited.



Manon Abud, facilitator at the Yellowknife regional dialogue

The online consultation, which began on February 9, was designed to enable both individuals and stakeholder organizations to provide detailed feedback on the framework document. Participants were guided through a special workbook that presented each goal and asked people to express their level of agreement with a series of statements. As well, people were invited to submit open-ended comments on each goal, and on the document as a whole. By the end of March, over 1,700 workbooks had been submitted, and respondents poured out tens of thousands of words of commentary.

Finalizing the Framework

The Mental Health Strategy Team will take the results of the consultation process to the meeting of the MHCC Board in May 2009, before finalizing the document during the summer. This will set the stage for moving on to the even more challenging task of defining measurable objectives for how to achieve the goals described in the framework for various segments of the population. During the second phase of the process of developing a mental health strategy for Canada, the Strategy Team will seek additional input from governments, stakeholders and individual Canadians. These consultations, along with the research work being done by the Commission and its Advisory Committees, will lead to the completion of all the elements of a mental health strategy for Canada by the fall of 2011.



Patrick Sudrau

Husband | Peer Support Coordinator | Likes fishing

My name is Patrick Sudrau and I have post traumatic stress disorder. It has affected me at the work level; it has affected me everywhere. My body has reactions that can be triggered by a scent, the sight of something, it can also be a vibration or a sound, and my body will return to a mode like when the traumas happened.

I was with the armed forces in Croatia in 1993 as a medical associate (today they are called medical technicians). During my six-month mission, I was on the front lines in the midst of bombings and battles. I had about eight traumatic events. However, it's impossible for me to say which one started it all; they were all stressful and traumatizing.

People around me told me, my wife told me too, that I had changed since my return from the mission. At the beginning I said, "That's not true, that's how I am." And then I realized, yes, I had changed and I needed help.

The most difficult things for me are having suicidal thoughts, panic attacks and nightmares, but they come mostly when I am tired.

What helps me with my recovery and my adaptation is therapy and medications — which I battled not to take for a while, but realized I have to take medications to get better. Also I've learned several tools to help me, depending on the situation; it can be breathing, meditation, stopping thoughts or going fishing. Fishing for me liberates my spirit in the sense that it's an activity during which I don't think about anything else. When I start, I have worries, but it doesn't take long for the worries to go away.

Now I am a coordinator for a peer support program at OSISS (Operational Stress Injury Social Support Program). It's a joint program between the Department of National Defense and Veterans Affairs Canada. My role is to offer peer support for military people and veterans who have psychological troubles after a mission or an operation. It's worthwhile work.

My ultimate objective is to return to my normal self — because we each have our own 'normal' — as quickly as possible when I am not feeling well.

The advice I can offer others is that the road to wellness can seem difficult, but it's worth the trouble. And have an open mind in your rehabilitation.

I've learned several tools to help me, depending on the situation; it can be breathing, meditation, stopping thoughts or going fishing.

Research Demonstration Project in Mental Health & Homelessness

An estimated 25 to 50% of homeless people have a mental illness and up to 70% of those with a severe mental illness also abuse substances. Almost a third of Canada's homeless are youths aged 16-24.

Homelessness is a significant social problem affecting thousands of people across Canada. In 1998, the Federation of Canadian Municipalities' Big City Mayors' Caucus declared homelessness in Canada a "national disaster." The United Nations Special Rapporteur on adequate housing described the situation in Canada as a "national crisis." In addition, the prevalence of mental health problems and addictions among homeless people is significantly higher than in the general population.

An estimated 25 to 50% of homeless people have a mental illness and up to 70% of those with a severe mental illness also abuse substances. Almost a third of Canada's homeless are youths aged 16-24. Street counts of homeless people indicate their numbers have increased at an alarming rate. For example, the homeless population in Vancouver grew by 235% from 1994 to 2006. Also of concern is the fact that Aboriginal peoples are disproportionately represented among the homeless and the mentally ill.

In February 2008, the federal government allocated \$110 million to the MHCC to find better ways to help the growing number of homeless people living with a mental illness. The funding is being used to undertake a four-year research demonstration project on mental illness in Canada's homeless population, in five Canadian cities — Vancouver, Winnipeg, Toronto, Montreal and Moncton. In each city, the project will target a distinct group of homeless people living with mental illness. In Vancouver, the project will focus on homeless people with a mental illness and substance abuse and addiction issues. In Winnipeg, the focus will be on urban Aboriginal people who are homeless and have a mental illness. In Toronto, ethno-cultural diversity, including new immigrants will be the focus. The project in Montreal will focus on the unique approaches to homelessness in Quebec, and in Moncton, the focus is on understanding best approaches in a smaller, quickly growing community with very limited mental health services. The Moncton project also includes a pilot study on services to homeless mentally ill individuals in rural communities.



Sonia Côté, Montreal Site Coordinator, Jayne Barker, MHCC Director of the Mental Health & Homelessness Initiative, and Cam Keller, Mental Health & Homelessness Project Manager

Across the five cities, 2,225 individuals will participate in the study; 1,325 of those individuals will receive housing and support services and the remainder will receive the usual services provided in that city. The objective is to determine the most effective ways of improving outcomes for homeless people living with a mental illness by providing them not only with housing, but also with a range of other supports and services. Ideally, that will result in more homeless people with mental illness returning to the community to lead full and productive lives.

The project is in the implementation stages in each of the five cities. As it moves forward, the Commission will continue to work collaboratively with provincial and municipal levels of government, researchers, local service providers and people with lived experience of mental illness and homelessness.

The objective is to determine the most effective ways of improving outcomes for homeless people living with a mental illness by providing them not only with housing, but also with a range of other supports and services.

Goal of the Initiative

The goal of the Mental Health & Homelessness Initiative (MH&HI) is to implement a research demonstration project in Canadian settings that will yield policy and program-relevant evidence about what service and system interventions achieve the best health and social outcomes for those who are homeless and mentally ill.

In this research demonstration initiative, a comparison of Housing First approaches to “care as usual” is being assessed. The primary goal is to identify best practices that could be applicable to other Canadian centres. In each city, funding is provided to a consortium involving researchers, service providers, governments and other stakeholders that will support the housing, services, and related research.

Long-Term Objectives of the MH&HI

The long-term objectives (to March 2013) are:

- To identify effective approaches to integrating housing supports and other supports and services or other “prerequisites” for success that promote housing stability, improved health and well-being, and long-term quality of life for homeless Canadians with mental illness;
- To contribute to the development of Best Practices and Lessons Learned that inform public policy and programmatic actions to address mental health and homelessness across Canada;
- To identify the unique problems of and solutions for diverse ethno-cultural and Aboriginal people within the homeless population;
- As a project legacy, enable support system improvements at each project site that address fragmentation through improved system integration and support including on the ground information technology solutions;
- To build service and evaluation capacity that endures after the project ends;
- To identify potential service approaches for youth within the homeless mentally ill population.

Accomplishments To Date

Significant work has been accomplished since February 2008. Highlights include:

Jurisdictional Partnerships / Intergovernmental Relations

An important aspect of the Research Demonstration Project in Mental Health and Homelessness is the engagement of provincial and local governments. In each of the five sites, the MHCC Board Chair and/or Senior MHCC Management staff have met with government officials to encourage partnerships, particularly in the area of sustainability. These meetings will continue over the course of the project. Government representatives will also be members of each site’s Local Advisory Committee.

National Research Team

The National Research Team includes seven experts and academics from Canadian universities who are helping to ensure nation-wide engagement of the research and academic community. This team has responsibility for providing advice regarding the design, methods and analysis of the core cross-city intervention project.

National Working Group

The National Working Group plays a problem-solving role and provides advice to project leaders regarding overall implementation of the Initiative, particularly in providing linkages between the five sites and ensuring that project objectives are met. The National Working Group is chaired by the MHCC Director of Policy and Research. Membership includes the site coordinator, principal investigator, and lead service agency representatives from each site, representatives from the National Research Committee, the Consumer Panel, and the Seniors, Service Systems, First Nations, Inuit and Métis, and Family Caregivers Advisory Committees of the MHCC.



Members of the National Working Group – Jason Champagne, Tim Aubry, Eric Latimer, Jino Distasio

Site Coordinators Hired

In the summer of 2008, site coordinators were recruited in Moncton, Toronto, Winnipeg and Vancouver. In January 2009, a site coordinator was hired for the Montreal project. Coordinators have since engaged other levels of government, and the research, service provider and mental health communities in their respective cities.

Identification of Lead Research and Service Agencies

In October 2008, the MHCC issued a Request for Applications outlining the service specifications and core research design requirements for proposals from each site. Only applications from coalitions of service providers, researchers and others were considered. A rigorous review process assessing the scientific merit as well as service and budget aspects of each proposal was conducted. As a result, principal investigators and lead service agencies have been identified for each site.

Community-Based Site Project Planning

Facilitated by the site coordinators and others, project planning for the five sites has been underway since April 2008. A wide range of stakeholders including researchers,

service providers, people with lived experience of mental illness and homelessness, and housing experts, worked together to identify how each site would approach this unique opportunity.

Consumer Panel

A panel of persons with lived experience of mental illness and homelessness is currently being established and will help guide the work of the project. Representatives from the Consumer Panel will also sit on the National Research Team and the National Working Group. Insight from Panel members will help ensure that the projects are truly taking into account the perspectives of people who are homeless and mentally ill.

Local Advisory Committees

Site coordinators are developing service partnerships and facilitating the appointment of Local Advisory Committees (LAC) in each of the five sites to ensure that the projects meet local needs and build on the strengths of local services. An open call for applications was posted for LAC membership and the committees will be formed so that they each include people with lived experience of mental illness and homelessness.



Members of the National Working Group – Don Robertson, Paula Goering, Greg Richmond

With the five site coordinators fully engaged in leading the projects in their cities, and lead research and service agencies identified, the Research Demonstration Project in Mental Health & Homelessness is well underway.

Complementary Research

An agreement has been reached with the Partnerships for Health System Improvement (PHSI) section of the Canadian Institutes of Health Research (CIHR), which will result in a significant leveraging of funds. Up to one million dollars from the MHCC and four million dollars from the CIHR has been designated for investments in research projects that will be complementary to the multi-site Research Demonstration Project in Mental Health & Homelessness. Proposals in the areas of youth homelessness and homelessness in the northern parts of Canada are of particular interest.

Key Objectives for the Coming Year

With the five site coordinators fully engaged in leading the projects in their cities, and lead research and service agencies identified, the Research Demonstration Project in Mental Health & Homelessness is well underway. The priorities for the coming year are:

- To engage the full range of participants needed for each research site;
- To engage the full range of partnerships needed for many aspects of each site;
- To ensure people with lived experience of mental illness and homelessness have a voice in all facets of the project implementation through their active participation;
- To secure enough housing to meet the needs of the project in all five sites;
- To announce to Canadians the full scope of the research demonstration projects.



Valérie Bilodeau

Police cadet | Volunteer | Likes art & swimming

My name is Valérie Bilodeau. I am 21 years old and I have bipolar disorder. It started when I was 14, at the end of the school year, with the stress of exams. There are episodes that are manic, and episodes that are depressive. All of the projects you start during a manic period, because you were full of ideas, can't be completed because they become like a mountain to climb. And the feeling amplifies and amplifies which creates anxiety. In the depressive phase you don't have the desire to do anything; there's lots of sleeping. The sleep you didn't get in the manic phase, you make up for in the depressive stage.

I have taken medications for several years, and for a little more than three years, I have not had any critical episodes. I see my doctor fairly frequently to talk about how it's going, and I have people around me who help — my boyfriend, my siblings, my father and mother — they are all people who help with my recovery.

Also, I participate in activities — I swim, do some artwork. I think it's about staying occupied, not pitying yourself about your situation, and knowing you can live a normal life even if you have a mental illness.

Currently I am a police cadet with the City of Montreal police service, mostly in the summer. I work with police officers, patrolling in parks, and helping with youth crime prevention. I'm sure it helps me because I love what I do. I consider the possibility of becoming a police officer, but it demands a lot of me, because I have to prove that I can really do this work. It's a job that is stressful and difficult, even for someone who doesn't have a mental health problem.

I also do volunteer work for a community organization that helps people with anxiety disorders, depression or bipolar disorder. It does a lot of good, to know you can help others.

There are a number of factors that make it difficult to live with the illness including the prejudices others can have towards it. My advice for people that don't have a mental illness, is not to judge without knowing, to become informed, to try to put yourself in the shoes of a person who has a mental illness — whatever it might be — because in the end, you never know when it could strike you.

My advice for people who have a mental illness — whatever it is — is to become informed. Search the internet, find organizations where you can get information, resources, and someone to talk to.

My advice for people that don't have a mental illness, is not to judge without knowing, to become informed, to try to put yourself in the shoes of a person who has a mental illness.

Anti-stigma/Anti-discrimination Initiative

The concept of stigma dates back to ancient Greece. It was a symbol that was tattooed or branded on slaves and criminals. Today, stigma refers to the way people are labeled. Labeling is so hurtful that people living with a mental illness often say the stigma and discrimination they experience at work, at school or at home can be worse than the disease itself. Stigma is a major barrier preventing people with mental health problems from seeking help.



MHCC Anti-stigma Team – Romie Christie, Micheal Pietrus

Based on the recommendations of the Senate Committee report, *Out of the Shadows at Last*, the Mental Health Commission of Canada has been given a mandate to engage in a 10-year initiative to reduce stigma and discrimination. Many believe that stigma and discrimination keep mental health issues in the shadows, away from the attention of the general public and government policy-makers.

Mental illness can affect everyone, individuals of every age and every walk of life. Some people say they find it easier to live with the illness than the stigma and discrimination associated with it.

The Anti-stigma / Anti-discrimination Initiative will be the largest systematic effort to reduce the stigma of mental illness in Canadian history. It will be a targeted outcomes-oriented strategic plan based on the best available research, and evaluated over time to measure its effectiveness.

The MHCC will work closely with the broad mental health community of consumers, stakeholders and professionals when creating the plan. The Commission will serve as a catalyst, mobilizing and focusing the actions of others. At the same time, it will help build a research knowledge base that will be shared with mental health scientists around the world.

The first two groups targeted as part of the Anti-stigma / Anti-discrimination Initiative are children and youth, and health care providers. Children and youth are important because early intervention makes an enormous difference over a lifetime. More than 70% of adults living with mental illness say the onset occurred before they were 18 years old. Health care providers have been chosen because, anecdotally, the first line of support is often where people seeking help say they experience some of the most deeply felt stigma and discrimination.

Accomplishments To Date

Over the past year, the Anti-stigma /Anti-discrimination Team has been collecting research and consulting with experts from other countries that have already developed anti-stigma/anti-discrimination programs. The Commission's strategy is to build on the strengths of existing knowledge and practices and tailor programs to Canadian requirements. At the same time, an important element has been to consult with stakeholders and consumers about the principles and values for this initiative to reach a consensus. Some of the highlights of the year's activities include:

"A Time for Action: Tackling Stigma and Discrimination"

A comprehensive consultant's report on stigma and discrimination was presented to the Commission in September 2007, which made 10 recommendations for action based on a broad review process including:

- A review of the literature designed to identify evidence-based research and promising practices;
- Interviews with Canadian and international experts to identify anti-stigma initiatives and provide advice to the Commission.

The complete report is available on the MHCC's website at www.mentalhealthcommission.ca.

Joint Symposium on Stigma in Mental Health and Addiction

On June 3, 2008, the Mental Health Commission of Canada and the Hotchkiss Brain Institute (HBI) in Calgary, Alberta, presented a joint symposium and roundtable on "Stigma in Mental Health and Addiction" at the University of Calgary. About 125 people representing many areas of the mental health field — from stakeholders and service providers to scientists and clinicians — attended the conference featuring four of the world's leading experts on stigma research.

The presentations were followed by a roundtable discussion moderated by Commission Chair, Michael Kirby. The talks centred on developing a plan to move forward with expanding stigma research capacity and evaluation in Canada. More than 20 people representing consumers, stakeholders, advocates, scientists, policy makers and MHCC Board members participated in the discussions.

A video presentation of the speakers and a report from the roundtable discussions are available for viewing on a joint website produced for the conference by the Commission and the HBI. The website can be accessed at www.mentalhealthstigma.ca or can be accessed from the Commission's website www.mentalhealthcommission.ca.

Advisory Committee Pilot Projects

An anti-stigma /anti-discrimination focus was integrated into the work plans of the Commission's Advisory Committees. One of the projects of the Child & Youth Advisory Committee, for example, saw the creation of a Youth Council comprised of young people from across Canada with lived experience of mental health problems. The Mental Health and the Law Advisory Committee is conducting an extensive review of current practices and possible improvements regarding the Not Criminally Responsible (NCR) provision which became part of the Criminal Code in Canada in the early 1990's. The Workforce Advisory Committee is filming prominent business leaders talking about changes needed in the workplace to improve mental health. The committee is also creating resources to help Canadian organizations make these changes happen.

Consensus

The major focus for 2008/09 was to develop consensus among stakeholders on how the Anti-stigma /Anti-discrimination Initiative should unfold. In September 2008, the President and CEO of the MHCC, Michael Howlett, and the Director of the Anti-stigma /Anti-discrimination Initiative, Micheal Pietrus, and his team, hosted twenty-five representatives from national mental health consumer, professional and non-profit organizations at a consensus meeting to create a vision, principles, and consensus statement to guide the ten-year initiative. The outcome of this meeting was a consensus document that includes a vision and guiding principles which are included below, and a consensus statement which is available on the MHCC website.

Consensus Vision

We envision a Canadian society that values and promotes mental health and wellness and is free from discrimination.



Patrick Baillie, Moderator, Mount Royal Symposium on Stigma

Consensus Guiding Principles

1. The Initiative will support and encourage all Canadians to lead by example in accepting, including and respecting others.
2. People living with mental health challenges and their natural supports must be invited to play a key role in developing and implementing the Anti-stigma / Anti-discrimination Initiative.
3. Any work done to promote mental health and decrease stigma and discrimination will contribute to the long-term sustainability of the Canadian health care system.
4. The Initiative will recognize and reflect the diversity of the Canadian population.
5. Cultural safety will be a cornerstone of the Anti-stigma / Anti-discrimination Initiative.
6. The Commission will work collaboratively with the mental health community to inform the development and implementation of the Anti-stigma / Anti-discrimination Initiative, further its objectives and develop effective, broad-based messaging about stigma and discrimination.
7. The MHCC will seek engagement with diverse partners including leaders, persons of influence and change agents in various sectors.
8. The activities of the Initiative will be informed by best / promising practices from research and lived experience and will incorporate lessons learned from evaluation.

Join the Consensus

All Canadians and interested organizations are invited to support the consensus agreement by logging onto the MHCC website and clicking on “Join the Consensus.”

Senior Consultant Appointed

The Commission announced the appointment of Dr. Heather Stuart, the leading Canadian expert on stigma reduction related to mental health, in November 2008. She has worked extensively with the World Psychiatric Association’s Global Anti-stigma Program and is the Chair and Co-founder of the World Psychiatric Association’s Scientific Section on Stigma and Mental Disorders. Dr. Stuart is currently collaborating with Statistics Canada to develop a stigma assessment module that can be incorporated into national health surveys.

Anti-stigma / Anti-discrimination Year One Planning Sessions

On December 1 and 2, 2008, two one-day planning sessions were held with stakeholders representing children and youth, and health care providers from across Canada. The purpose of the meetings was to build consensus on strategic directions and explore key issues related to the roll-out of the Initiative.

Reference Groups

Following the two planning sessions, representatives from the national health care professional associations created a “Mental Health Table” to consult with the Commission’s Anti-stigma Team. An adult Consumer Reference Group, composed of people from across Canada living with a mental illness, will be created to consult with the Anti-stigma Team.

Pilot Symposium on Mental Illness and Stigma in the Media and in Society

In March 2009, a pilot symposium was hosted by the Mental Health Commission and Mount Royal College in Calgary, Alberta, to encourage change in the ways we support people with mental health problems in the health care system and also in the words we use to describe them in the media. Six speakers shared various perspectives, including lived experience, research and media. More than 330 students from journalism, health care, social work and justice programs as well as stakeholders participated in two sessions. They completed a research questionnaire to determine if the information they were exposed to in the sessions helped to change their perceptions of and attitudes towards people with mental illness. Results of the research will be used going forward, in planning future symposiums for students across Canada.

Pilot Projects

In early April 2009, the Anti-stigma Team will send two “Requests for Interest” (RFI) seeking proposals from groups or individuals across Canada already involved in operating programs targeted at reducing stigma and discrimination related to mental illness. The purpose of the RFIs is to identify and then engage organizations to partner with the Commission. Programs that are selected

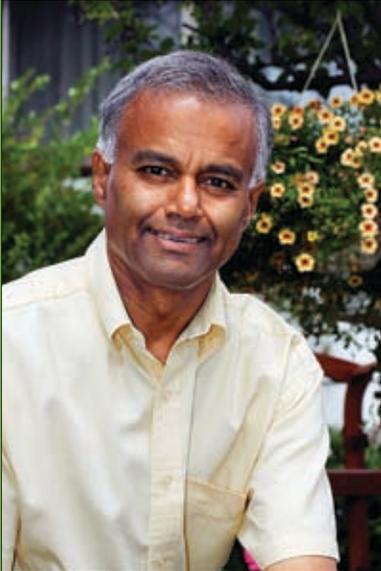


A full house at the Mount Royal Symposium on Stigma

will be evaluated for their effectiveness and potential to be implemented nationwide. Another benefit of this process will result in the creation of an inventory of such programs currently underway across the country. A group of independent experts representing a broad cross section of stakeholders from Canada, the U.S. and Europe will help select the successful applicants and will provide on-going advice.

Going Forward

The Anti-stigma/Anti-discrimination Initiative is well underway with the first projects targeted at children and youth and health care providers scheduled to roll out in the coming months.



Jamal Ali

Teacher | Advocate | Volunteer

I am Jamal Ali, and I am 52 years old. I was diagnosed with schizophrenia in 1981. Before I was diagnosed with schizophrenia, I was a very happy, sociable, and energetic individual. I got a job as a computer operator. The first six months on the job I was doing very well. Opportunities for advancement were great. In the seventh month, I was in a depressed state of mind. I couldn't concentrate on my job, I was falling asleep by the computer terminal, neglecting my duties. I would see visions of myself, wandering from place to place, being abandoned and scorned by others, and people passing by spitting on me. That was my hallucination, and it really frightened me. I was terminated in my eighth month on the job, and the termination made my illness worse because I worried about my future. What next? What was I going to do for the rest of my life?

When I was diagnosed with schizophrenia, I couldn't accept it. I was in a state of denial. I thought that having schizophrenia meant you were insane. Because of my thoughts regarding schizophrenia, the fear of the stigma from society — what would people and my friends think of me, once they found out I had this — I saw my psychiatrist for almost two decades, and lived in isolation in my parents home.

I eventually thought about what would happen to me once my parents passed away. They're not going to be around forever. I had no job, no income. I would end up on the streets. Many people with mental health issues are afraid to come out and speak about it, or to access help because of the fear of the stigma. It takes courage, that's all.

When I talk to students about my experience with schizophrenia, I feel mentally well. It empowers me. It's part of my journey of wellness. I feel that I'm achieving something, helping to erode the stigma.

My advice to other people who are struggling with this disorder or any other form of mental illness, is to seek help, don't be afraid. There's nothing to be afraid of. And I would advise them — they are not responsible for their situation. And once they seek help, then things will work out well for them.

My advice to other people who are struggling with this disorder or any other form of mental illness, is to seek help, don't be afraid.

Knowledge Exchange Centre

The purpose of the Knowledge Exchange Centre (KEC) is to provide a national, reliable and comprehensive “point of access” to information and knowledge about mental health issues and related topics, primarily through the web.

The purpose of the Knowledge Exchange Centre (KEC) is to provide a national, reliable and comprehensive “point of access” to information and knowledge about mental health issues and related topics, primarily through the web. Knowledge exchange can play an important role in linking “communities of interest” so that they can share information and experiences. Research suggests that the KEC should focus on bridging the knowledge to practice gap, consequently, there will be a strong focus on promoting information, knowledge and skills that are based on evidence, experience, and promising practices.

The KEC will develop incrementally by first identifying priority target groups and providing access to knowledge of interest to those groups. Two of the initial target groups will include persons living with a mental illness, and their families and key support people. Over time, the KEC will provide knowledge to a wide range of target groups.

The Knowledge Exchange Centre will take a collaborative approach and work in partnership with other organizations already involved in knowledge exchange to avoid duplication. It will adopt and refine an approach to standardize web-based material and create a “network of networks” that links together the many existing websites and sources of information. Where there are knowledge gaps, KEC will work with stakeholders to develop knowledge exchange initiatives to fill these gaps.

Over time, the KEC will move beyond provision of information to creating opportunities for interaction among users and exchange of information. It will provide a forum to support the translation of knowledge into action and to share information on the outcomes of these activities.

In addition to web-based activities, KEC will support conferences and symposia, provide a newsletter and other publications and possibly develop a 1-800 number to support access to Knowledge Exchange Centre materials for those who have no access to the internet, particularly those with disabilities needing help to access information.

Going Forward

Research indicates that sustainability of knowledge exchange requires formal, ongoing infrastructure. Over the next year, MHCC will begin the process of developing the human and technological capacity to support its mission. When the recruitment of a Director for the KEC initiative is complete, the first priority will be to create a strategic plan. A national editorial board will also be established to oversee the content of the KEC.

Partners for Mental Health

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

Margaret Mead

Vision

A national network of people dedicated to improving mental health services and supports in Canada, who will work together to ensure that families, communities and workplaces are mentally healthy, vibrant, supportive and strong.

Mission

To create a movement in Canada that becomes the enduring voice for the transformation of mental health services and supports, and leads the battle to eliminate the stigma and discrimination faced by people living with a mental illness.

Over the course of a lifetime, virtually no one is left untouched by mental health issues. As a result, many people are likely to be willing to join in the efforts to improve the health and social outcomes for people living with mental health problems and the families that support them.

In considering how to achieve a profound transformation of both the mental health system and of attitudes toward people living with a mental illness, the Commission has examined other illness-oriented organizations that have successfully established a strong presence in Canadian life and a place on both the public and private sector agendas. It is clear that there is much to be learned from organizations that exist for breast cancer, diabetes, heart disease and stroke, and AIDS.

An integral component of Partners for Mental Health will be a strong group of dedicated individuals with a willingness to educate others about mental illness, advocate for change in the quality of mental health services, and ensure there is a strong national emphasis on promotion, prevention and early intervention.

Through a variety of means — including education campaigns and making knowledge and information more easily accessible — each successful illness-oriented organization has made the health cause they champion better understood by all Canadians, and in particular by public and private sector policy makers. In addition, public discussion of

these illnesses is now acceptable, even though some of them, such as breast cancer and AIDS, were once highly stigmatized.

At the heart of these organizations are committed and passionate individuals that contribute in many ways. They raise money, volunteer in health institutions, mount campaigns to persuade government to increase funding for treatment and research, talk openly about their experiences, and make sure that the public never loses sight of their concerns. We can and must duplicate the success of these organizations by creating one that is focused on mental health and mental illness.

It will be a much greater challenge to successfully transform the mental health system without a broadly-based, dynamic and well-organized grassroots group of individuals. It is for this reason that the Partners for Mental Health program has been given such high priority by the Mental Health Commission.

Accomplishments To Date

Meeting with National Movement Expert Advisors

In February 2008, MHCC Chair, Michael Kirby, President, Michael Howlett, and Director of Communications, Micheal Pietrus, hosted a meeting of expert advisors in Toronto, on the topic of “Building a National Movement.” The purpose of the meeting was to assemble a team of experts in social change to help the Mental Health Commission identify the strategies needed to achieve a national movement. A document summarizing the “lessons learned” by each of the experts was compiled as a result of this meeting. This document will contribute to the planning and implementation stages of the Partners for Mental Health Program.

Priorities for Fiscal Year 2009/10

Partners for Mental Health will officially be launched in 2009/10. The Director of the Partners for Mental Health program will lead the planning process to clarify the role and function of the program and establish its essential goals and objectives. A key priority will be to determine how Partners for Mental Health will contribute to the development of the Mental Health Strategy for Canada, the Anti-stigma / Anti-discrimination Initiative, and the Knowledge Exchange Centre.

Advisory Committees

Eight advisory committees, chaired by experts in their fields, have been set up to provide advice to the MHCC Board and to support the Commission in engaging with the broader stakeholder community. The eight advisory committees are currently working on a total of 24 different projects which are integral to the Commission's key initiatives.

Child & Youth Advisory Committee



Simon Davidson
Chair, Child & Youth
Advisory Committee

The Child & Youth Advisory Committee (CYAC) is chaired by Simon Davidson, Executive Director of the Provincial Centre of Excellence for Child and Youth Mental Health and the Chief of Psychiatry, Children's Hospital of Eastern Ontario (CHEO), Ottawa.

The work of the CYAC is essential to the success of the MHCC as more than 70% of adults with mental health issues first experience symptoms in childhood and adolescence. Identifying children and youth at risk, and intervening as close to onset as possible, is of paramount importance in improving quality of life and productivity. The Committee is working on projects to:

- Develop a Canadian vision for child and youth mental health;
- Support the delivery of evidence-based mental health services for children and youth within the school setting;
- Support the child and youth segment of the national anti-stigma initiative;
- Identify, understand and promote effective strategies to address family unit stigma;
- Establish a youth council;
- Develop an index of current local, national and international knowledge exchange initiatives and establish a Canadian consortium for knowledge exchange in child and youth mental health;
- Systematically compile, review, and synthesize material for the knowledge exchange related to child and youth mental health to meet the needs of various stakeholders.

Family Caregivers Advisory Committee



Ella Amir
Chair, Family Caregivers
Advisory Committee

The Family Caregivers Advisory Committee (FCAC) is chaired by Ella Amir, Executive Director for the past nineteen years of AMI-Quebec Action on Mental Illness (formerly Alliance for the Mentally Ill), Montreal.

The FCAC's vision is that families (and other supporters) will be provided with relevant information, education, guidance and support in a culturally sensitive and competent way, so they can best help ill relatives throughout the course of their illnesses. The hardships that come with long-term care often affect the caregiver's own well-being. Therefore, proper support is required so that families can exercise their responsibilities as caregivers while maintaining the integrity of their own well-being. Another role of the FCAC is to ensure the Commission's work prioritizes families along with people with mental illness.

The FCAC is working on a project to set up a structure for virtual peer support for family caregivers. The project is telephone based and will start in Ontario and gradually expand to other provinces.

First Nations, Inuit and Métis Advisory Committee



William Mussell

Chair, First Nations, Inuit and Métis Advisory Committee

The Chair of the First Nations, Inuit and Métis Advisory Committee (FNIMAC), William (Bill) Mussell is a member of the Skwah First Nation, Chilliwack Landing, British Columbia, and has been the President and Chair of the Native Mental Health Association of Canada for 15 years.

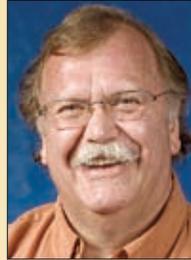
The FNIMAC is dedicated to promoting overall mental health and well-being among Indigenous people throughout Canada. The Committee includes First Nations, Inuit, Métis and non-Indigenous members from across Canada working collaboratively on projects that will:

- Promote “cultural safety” as a value, principle, and practice in the provision of mental health services and the training of practitioners in the field of mental health;
- Ensure that cultural safety becomes a pillar of the MHCC anti-stigma campaign;
- Develop and promote Indigenous-determined ethical guidelines for the design and delivery of frontline mental health and addictions programming in Indigenous communities.

The FNIMAC intends to help increase knowledge and understanding with respect to issues of cultural safety, social justice, and ethical accountability by highlighting the successes being made by Aboriginal Peoples. The Committee believes the challenges related to historical issues that undermined the substance of family and community life will be overcome through partnerships that build on the strengths of Indigenous and non-Indigenous cultures.

The issues and needs pertaining to Canada’s Aboriginal citizens have a cross-cutting effect on much of the work of the Commission and its projects will contribute to the enhancement of the mental health system for all Canadians.

Mental Health and the Law Advisory Committee



Edward Ormston

Chair, Mental Health and the Law Advisory Committee

The Chair of the Mental Health and the Law Advisory Committee (MHLAC), Edward (Ted) Ormston, was appointed to the Ontario Court of Justice in 1989 and is currently seconded to act as Chair of the Mental Health Consent and Capacity Board.

The MHLAC will examine how society considers the rights of people with a mental illness, particularly the way in which the legal system impacts the human rights of those with mental health problems. The MHLAC is currently working on projects to:

- Develop tools to assess how the law currently impacts the human rights of people with mental health problems;
- Examine best practices in police services regarding interactions with people with a mental illness;
- Examine the operation of current criminal justice provisions for individuals declared not criminally responsible on account of mental disorder (NCRMD) and under the authority of a provincial or territorial review board as well as the antecedents and trajectories of NCRMD accused, including mental health and criminal justice involvement, review board decision-making, and mental health and criminal outcomes;
- Examine the evolution of procedures and best practices in mental health care for correctional facilities.

Science Advisory Committee



Elliot Goldner
Chair, Science
Advisory Committee

The Science Advisory Committee (SAC) is chaired by Elliot Goldner, Professor in the interdisciplinary Faculty of Health Sciences at Simon Fraser University. He also established and was the founding director of the Centre for Applied Research in Mental Health & Addiction (CARMHA), Faculty of Health Sciences, Simon Fraser University.

The SAC provides advice to the MHCC on matters of science, acting in a facilitating/advisory/consulting expert role and proposing scientific activities considered to be important to the mission of the MHCC. Advice may include: information about existing scientific evidence, knowledge that can inform policy decisions, identification of needs and opportunities to advance research and scientific discovery, development of MHCC-sponsored scientific activities and capacity development, strategic advice regarding collaboration with scientific organizations, matters of scientific ethics and other topics. The (SAC) applies a broad and interdisciplinary approach to scientific matters.

The SAC is working on projects to:

- Develop a network for consumers to engage in research projects related to mental health;
- Develop and evaluate resources, including online materials and national networking strategies, to facilitate multicultural mental health service delivery.

Seniors Advisory Committee



Marie-France Tourigny-Rivard
Chair, Seniors
Advisory Committee

The Seniors Advisory Committee (SenAC) is chaired by Marie-France Tourigny-Rivard, a Professor in the Department of Psychiatry, University of Ottawa and Clinical Director of the Integrated Geriatric Psychiatry Program, Royal Ottawa Health Care Group.

The mission of the SenAC is to ensure that the mental health of seniors is addressed through the inclusion of a lifespan perspective across all the work of the Commission. Recognizing that mental illness is not a normal or inevitable consequence of aging, the committee wishes to ensure that all seniors have access to services and care that respond to their mental health needs, including services promoting quality of life and overall health.

The committee is addressing all priorities of the MHCC including:

- Updating previously published guidelines for services for seniors with psychiatric disorders to reflect the goals of the National Strategy for Services and take into account significant changes and challenges in service delivery across the country;
- Identifying strategies and tools that will help the Commission's anti-stigma campaign reach seniors, their families and health professionals;
- Developing an Issues and Options paper on Knowledge Exchange and Transfer based on the experience of existing knowledge exchange networks that focus on seniors, mental health and dementia.

Service Systems Advisory Committee



Steve Lurie
Chair, Service Systems
Advisory Committee

Steve Lurie, Executive Director of the Canadian Mental Health Association, Toronto Branch, chairs the Service Systems Advisory Committee (SSAC).

The mission of the SSAC is to provide advice to the Commission on the elements necessary to create high-performing mental health systems that meet the needs of people living with a mental illness. Those elements include, but are not limited to: diversity, peer support/consumer-operated programs, supportive housing, health human resources planning, concurrent disorder capacity and the interface between primary health care and mental health systems across the country. The Committee's work encompasses areas of federal jurisdiction as well as provincial systems. Current priorities include:

- A review to examine the range of supports and services directed and provided by people who live with mental illness. Ensure the inclusion of peer-support and consumer-directed services are identified as better practice in the provision of comprehensive mental health care;
- Understand issues, best practices and options for service development to meet the needs of ethno-cultural groups, immigrants, refugees and racially marginalized groups;
- Examine regional and local readiness to develop housing and related supports for people living with a mental illness.

Workforce Advisory Committee



Ian Arnold
Chair, Workforce
Advisory Committee

The Workforce Advisory Committee (WAC) is chaired by Ian Arnold, Consultant in Health, Safety, and Environment and Adjunct Professor, Faculty of Medicine, McGill University. WAC members come from a number of different workforce backgrounds. The WAC is working on projects to:

- Encourage CEOs and other senior organizational leaders to make a decisive commitment and take action towards how mental health is viewed and managed in the workplace, and to provide a resource that assists in decision-making about where to start and where to invest. The WAC is partnering with the Canadian Society for Training and Development (CSTD) for this project;
- Assist people living with mental health problems and illnesses who have never worked, who have not been in the workforce for a prolonged period of time, or who suffer from episodic mental illness and for whom disability coverage is inadequate to establish meaningful employment. This project will undertake a review of "promising practice" in existing Canadian employment initiatives (e.g. supported employment, peer-run/alternative businesses, corporate sector, etc.) and develop a "legislative model" for disability benefits;
- Identify, develop and disseminate a best practice model that will provide guidance for Canadian employers with respect to supporting employees living with mental health problems and illnesses.

Mental Health Commission of Canada

Auditors' Report

To the Board of Directors
Mental Health Commission of Canada

We have audited the statement of financial position of Mental Health Commission of Canada (the "Commission") as at March 31, 2009 and the statements of operations and changes in net assets and cash flows for the year then ended. These financial statements are the responsibility of the Commission's management. Our responsibility is to express an opinion on these financial statements based on our audit.

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

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Commission as at March 31, 2009 and the results of its operations and its cash flows for the year then ended in accordance with Canadian generally accepted accounting principles.

KPMG LLP

Chartered Accountants

Calgary, Canada
May 30, 2009



Mental Health Commission of Canada

Statement of Financial Position
March 31, 2009, with comparative figures for 2008

	2009	2008
Assets		
Current assets		
Cash and cash equivalents	\$ 4,003,846	\$ 958,763
Grant and accounts receivable	89,791	728,708
Deposits and prepaid expenses	55,402	39,726
	4,149,039	1,727,197
Capital assets (note 3)	814,886	986,637
	\$ 4,963,925	\$ 2,713,834
Liabilities and Net Assets		
Current liabilities		
Accounts payable and accrued liabilities	\$ 1,179,954	\$ 1,712,801
Deferred contributions – operating (note 4)	2,947,336	14,396
	4,127,290	1,727,197
Deferred capital contributions (note 5)	814,886	986,637
Net assets:		
Net assets	21,749	—
Commitments (note 6)		
Contingency (note 7)		
Subsequent event (note 10)		
	\$ 4,963,925	\$ 2,713,834

See accompanying notes to financial statements.

Approved on behalf of the Board:


Michael Kirby, Director


Fern Stockdale Winder, Director

Mental Health Commission of Canada

Statement of Operations and Changes in Net Assets

Year ended March 31, 2009, with comparative figures for 2008

	2009	2008
Revenue:		
Grant income (note 4)	\$ 7,883,477	\$ 4,138,325
Interest income	21,749	20,492
	7,905,226	4,158,817
Expenses:		
Salaries and benefits	3,102,407	557,709
Services	2,357,782	2,455,093
Travel	1,061,489	135,395
Meetings and events	416,520	643,343
Materials	361,732	216,891
Rent	284,352	57,184
Amortization	299,195	93,202
	7,883,477	4,158,817
Excess of revenue over expenses	\$ 21,749	\$ —
Net assets, beginning of year	—	—
Net assets, end of year	\$ 21,749	\$ —

See accompanying notes to financial statements.

Mental Health Commission of Canada

Statements of Cash Flows
Years ended March 31, 2009 and 2008

	2009	2008
Cash provided by (used in):		
Operations:		
Excess of revenues over expenses	\$ 21,749	\$ —
Items not affecting cash flows:		
Amortization of deferred capital contributions	(299,195)	(93,202)
Amortization	299,195	93,202
	21,749	—
Net change in non-cash working capital balances:		
Grant and accounts receivable	638,917	(728,708)
Deposits and prepaid expenses	(15,676)	(39,726)
Accounts payable and accrued liabilities	(532,847)	1,712,801
Deferred contribution	2,932,940	14,396
	3,045,083	958,763
Investing and financing:		
Purchase of equipment	(127,444)	(1,079,839)
Deferred capital contributions	127,444	1,079,839
	—	—
Net increase (decrease) in cash during the year	3,045,083	958,763
Cash, beginning of year	958,763	—
Cash, end of year	\$ 4,003,846	\$ 958,763
Supplemental information:		
Interest received	\$ 21,749	\$ 20,492

See accompanying notes to financial statements.

Mental Health Commission of Canada

Notes to the Financial Statements Year ended March 31, 2009

1. Description of the business:

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

- (a) To facilitate and animate a process to elaborate a mental health strategy for Canada;
- (b) To build a Pan-Canadian Knowledge Exchange Centre that will allow governments, providers, researchers and the general public to access evidence-based information about mental health and mental illness and to enable people across the country to engage in a variety of collaborative activities;
- (c) To develop and implement a 10 year initiative to reduce the stigmatization of mental illnesses and eliminate discrimination against people living with mental health problems and mental illnesses; and
- (d) To conduct multi-site, policy relevant research that will contribute to the understanding of the effectiveness and costs of service and system interventions to achieve housing stability and improved health and well-being for those who are homeless and mentally ill.

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

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

2. Significant accounting policies:

- (a) Change in accounting policies:

Financial instruments:

Effective April 1, 2008 the Commission adopted the following new Canadian Institute of Chartered Accountants (CICA) Handbook Sections: Section 1535 Capital Disclosure, Section 3862, Financial Instruments – Disclosure and Section 3863, Financial Instruments – Presentation.

Section 1535 requires the disclosure of both qualitative and quantitative information that enables users of financial statements to evaluate the Commission's objectives, policies and processes for managing capital.

Section 3862 and Section 3863 consists of a comprehensive series of disclosure requirements and presentation rules applicable to financial instruments. Section 3862 revives and enhances the disclosure requirements set out in Section 3861 and 3863 carries forward unchanged the presentation requirements of Section 3861.

- (b) Financial statement presentation:

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

- (c) Revenue recognition:

The Commission follows the deferral method of accounting for contributions.

Restricted contributions are recognized as revenue in the year in which the related expenses are incurred. Unrestricted contributions are recognized as revenue when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured.

These financial statements reflect agreed arrangements approved by Health Canada with respect to the year ended March 31, 2009.

- (d) Cash and cash equivalents:

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

- (e) Capital assets:

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

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

- (f) Financial instruments:

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

Mental Health Commission of Canada

Notes to the Financial Statements Year ended March 31, 2009

2. Significant accounting policies (continued):

(f) Financial instruments (continued):

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

Financial instruments of the Commission consist of cash and cash equivalents, grant and accounts receivable and accounts payable and accrued liabilities. Except where otherwise disclosed, as at March 31, 2009, there are no significant differences between the carrying values of these instruments and their estimated market values.

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

(g) Use of estimates

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

(h) Comparative figures:

Certain comparative figures have been reclassified to conform to the financial statement presentation adopted in the current year.

(i) Future accounting pronouncements:

Recent amendments to Section 4400, Financial Statement Presentation by Not-for-Profit Organizations, will modify the requirement with respect to various elements of financial statement presentation. These amendments include:

- (i) Reporting certain revenues at their gross amounts in the statement of revenue and expenditures.
- (ii) When a non-for-profit organization classifies its expenses by function and allocates some of its fundraising and general support costs to another function, disclosing the policy adopted for expenses and amounts allocated from each of these two functions to other functions.
- (iii) The elimination of the requirement to treat net assets invested in capital assets as a separate component of net assets.
- (iv) Cash flows from investing and financing activities must be disclosed separately.

The new standard applies to financial statements relating to the fiscal years beginning on or after January 1, 2009. This standard will impact the Commission's disclosure provided but will not affect the Commission's results or financial position.

3. Capital assets:

			2009		2008	
	Cost	Accumulated Cost amortization	Net book value		Net book value	
Computer hardware	\$ 5,619	\$ 4,214	\$ 1,405	\$	\$ 4,214	
IT infrastructure	105,933	31,780	74,153		95,340	
Software	181,354	117,607	63,747		108,404	
Office equipment	106,688	15,152	91,536		20,174	
Furniture	179,365	53,810	125,555		161,429	
Leasehold improvements	628,324	169,834	458,490		597,076	
	\$ 1,207,283	\$ 392,397	\$ 814,886	\$	\$ 986,637	

4. Deferred contributions related to operations:

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

	2009		2008	
Balance, beginning of year	\$	14,396	\$	—
Grants received		10,633,437		5,139,358
Less amount recognized as revenue		(7,883,477)		(4,138,325)
Amounts related to deferred capital contributions		171,751		(986,637)
Other adjustments		11,229		—
Balance, end of year	\$	2,947,336	\$	14,396

5. Deferred capital contributions:

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

Mental Health Commission of Canada

Notes to the Financial Statements
Year ended March 31, 2009**5. Deferred capital contributions (continued):**

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

	2008	2007
Balance, beginning of year	\$ 986,637	\$ —
Capital contributions	127,444	1,079,839
Amounts amortized to revenue	(299,195)	(93,202)
Balance, end of year	\$ 814,886	\$ 986,637

6. Commitments:

The Commission rents premises under operating leases which expire, at the latest, in 2013. Minimum annual rental payments to the end of the lease terms are as follows:

2010	\$ 233,676
2011	216,506
2012	192,467
2013	192,467
	\$ 835,116

7. Contingency:

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

8. Financial instruments and related risks:

Fair values:

The fair value of financial assets and liabilities approximate their carrying amounts due to the imminent or short-term nature of these financial assets and liabilities or their respective terms and conditions.

Risk Management:

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

(i) Credit risk:

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

The Commission is exposed to credit risk on its grants and accounts receivable from another organization. Concentration of credit risk arises as a result of exposures to a single debtor or to a group of debtors having similar characteristics such that their ability to meet contractual obligations would be similarly affected by changes in economic, political, or other conditions. The Commission monitors credit risk by assessing the collectability of the amounts. Of the grants and accounts receivable at year end, \$72,044 relates to expenditures incurred on behalf of a registered charity, which is in its start-up phase, that supports the mandate of the Commission and has a common chair of the board of directors. In addition, \$17,096 relates to other receivables. As at March 31, 2008, the Commission did not have a provision for doubtful accounts due to the nature of the receivables as all amounts will be considered readily collectible.

(ii) Market risk:

Market risk is the risk that change in market prices, interest rate levels, indices, liquidity and other market factors will result in losses. The Commission is not exposed to significant market risk.

(iii) Interest rate risk:

Interest rate risk arises on cash and cash equivalents. The Commission is exposed to interest rate risk due to fluctuations in bank's interest rates. The Commission does not hedge its exposure to this risk as it is minimal. Every 1% fluctuation in the bank's interest rate results in a \$40,038 annual change in interest revenue.

9. Capital management:

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

10. Subsequent event:

In accordance with the terms and conditions of the Funding Agreement, on April 15, 2009 Health Canada transferred \$107,681,533 to the Commission. These funds pertain to Commission's initiative for research related to the homeless mentally ill and are maintained in a segregated bank account maintained by a custodian banker until required for operations.

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