SENATE SÉNAT
CANADA

REPORT 4

A Proposal to Establish A Canadian Mental Health Commission

Interim 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*

October 2005

Ce document est disponible en français

Available on the Parliamentary Internet:
www.parl.gc.ca
(Committee Business – Senate – Recent Reports)
38th Parliament – 1st Session

The Standing Senate Committee on Social Affairs, Science and Technology

Interim Report on
Mental Health, Mental Illness and Addiction

Report 4

A PROPOSAL TO ESTABLISH A CANADIAN MENTAL HEALTH COMMISSION

Chair
The Honourable Michael J.L. Kirby

Deputy Chair
The Honourable Wilbert Joseph Keon

October 2005

TABLE OF CONTENTS

ORDER OF REFERENCE

Extract from the *Journals of the Senate* for Thursday, October 7, 2004:

The Honourable Senator Kirby moved, seconded by the Honourable Losier-Cool:

That the Standing Senate Committee on Social Affairs, Science and Technology be authorized to examine and report on issues arising from, and developments since, the tabling of its final report on the state of the health care system in Canada in October 2002. In particular, the Committee shall be authorized to examine issues concerning mental health and mental illness.

That the papers and evidence received and taken by the Committee on the study of mental health and mental illness in Canada in the Thirty-seventh Parliament be referred to the Committee; and

That the Committee submit its final report no later than December 16, 2005 and that the Committee retain all powers necessary to publicize the findings of the Committee until March 31, 2006.

The question being put on the motion, it was adopted.

Extract from the *Journals of the Senate* for Thursday, October 20, 2005:

The Honourable Senator Kirby moved, seconded by the Honourable Senator Pépin:

That, notwithstanding the Order of the Senate adopted on Thursday, October 7, 2004, the Standing Senate Committee on Social Affairs, Science and Technology, which was authorized to examine and report on issues arising from, and development since, the tabling of its final report on the state of the health care system in Canada in October 2002 (mental health and mental illness), be empowered to present its final report no later than June 30, 2006, and that the Committee retain all powers necessary to publicize the findings of the Committee contained in the final report until October 31, 2006; and

That the Committee be permitted, notwithstanding usual practices, to deposit any report with the Clerk of the Senate, if the Senate is not then sitting; and that the report be deemed to have been tabled in the Chamber.

After debate,

The question being put on the motion, it was adopted.

ATTEST:

Paul C. Bélisle

Clerk of the Senate

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
Joyce Fairbairn, P.C.
Aurélien Gill
Marjory LeBreton
Lucie Pépin
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, Forrestall, Johnson, Kinsella, Léger (retired), Lynch-Staunton, Mercer, Milne, Morin (retired), Murray, Pearson, Robertson (retired), St.Germain, Stratton and Tardif.

A PROPOSAL TO ESTABLISH A CANADIAN MENTAL HEALTH COMMISSION

1. RATIONALE: WHY A COMMISSION?

In its forthcoming final report on mental health, mental illness and addiction in Canada, *Out of the Shadows at Last*, the Standing Senate Committee on Social Affairs, Science and Technology will recommend the creation of a Canadian Mental Health Commission. Several factors led the Committee to this recommendation:

a) Although the Committee's work and, importantly, recent actions by provincial governments have begun to focus a much-needed spotlight on mental health, it remains a fact that the whole complex, pervasive problem of mental illness and addiction in Canadian society has been neglected for many years. The Canadian Mental Health Commission will provide a much needed national (*not federal*) focal point that will keep mental health issues in the mainstream of public policy debates in Canada until effective solutions are developed and implemented.

b) Those most directly affected are people living with mental illness, their families, friends and employers. But, given that one in five Canadians will experience a significant episode at some point during their lifetime, virtually every Canadian will be affected by mental illness and/or addiction, directly or indirectly. Mental illness is truly a national concern.

c) No single level of government has the resources needed to deal with the full range of mental health issues on its own. Creating a national focus will add substantial value, especially with respect to exchanging information and facilitating collaboration among governments and between governments and stakeholders.

d) In the private sector, the cost of mental illness and addiction constitutes the most rapidly increasing health care expense. It is estimated to cost Canadian companies currently about $18 billion a year. The economic as well as the social implications are both obvious and of concern to everyone.

e) In every government, responsibility for mental health issues is dispersed among several departments and agencies – health, social services, housing, etc. Managing issues that span ministerial boundaries is notoriously hard; truly effective ways of doing so are few and far between. The Canadian Mental Health Commission will benefit all governments by facilitating the exchange of information on best practices on how to deal with this classic inter-departmental issue.

f) There is, as well, no easy mechanism now available for stakeholders in the mental health sector to exchange knowledge and distribute information about best practices coast to coast to coast. A national Knowledge Exchange Centre will be an integral part of the Canadian Mental Health Commission.

g) Canadians must become better educated about the reality of mental illness. They must be encouraged to understand and be more tolerant of people living with mental illness and addiction. To those ends, a national campaign is needed to combat the stigma and discrimination associated with mental illness. Such a campaign will be most effectively managed nationally by the Canadian Mental Health Commission.

The Committee considered alternatives to the creation of a national mental health commission. It concluded, however, that no existing organization has a mandate which encompasses or could be modified to encompass a majority of the factors set out above.

While mental health falls naturally under the purview of the Health Council of Canada, its chair, Michael Decter, has told the Committee that it will be some years before the Council's extremely full agenda will be cleared sufficiently to address mental health adequately. The Health Council's mandate also includes monitoring the performance of all government health care systems. The Canadian Mental Health Commission proposed by the Committee explicitly will *not* have any role in monitoring any government's performance in dealing with mental health and addiction.

The mandate of the Canadian Centre on Substance Abuse is too narrow to encompass the range of mental health issues of concern to the Senate Committee. Moreover it has no role in changing public attitudes.

Therefore a new national organization is required.

It must be emphasized, however, that the success of the proposed Commission in contributing to improvement of the mental health of Canadians depends critically upon their being in place strong structures and committed people at the provincial and territorial level to translate policy, knowledge and ideas into action on the ground. This is true also with respect to the mental health services provided by the federal government through the First Nations and Inuit Health Branch of Health Canada and through the Correctional Service Canada.

The Committee's intention is that the work of the Canadian Mental Health Commission will complement that being done by existing structures and people at the federal, provincial and territorial levels.

Finally, consistent with its view that structural solutions to any problem should not be permanent, the Committee will recommend that the Commission "sunset" in ten years.

2. GUIDING PRINCIPLES OF THE CANADIAN MENTAL HEALTH COMMISSION?

The key principles are that the Commission:

- Be an independent not-for-profit organization at arms-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;
- Build on and complement initiatives already underway and avoid duplicating the roles and activities of those currently working in mental health;
- Establish partnerships with governments, employers, mental health research organizations and service providers, other health care organizations, and with the spectrum of national and international mental health stakeholders;
- Put its emphasis on evidence-based mental health policies and methods of service delivery;
- Rigorously evaluate, assess and report on its own activities in order to ensure their appropriateness and efficacy and to maintain the Commission's credibility with governments, its collaborating stakeholders and the Canadian public.

3. MISSION/MANDATE OF THE COMMISSION

The mission of the Commission is:

- 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 provide a national focal point for objective, evidence-based information on all aspects of mental health and mental illness;
- To be a source of information to governments, stakeholders and the public on mental health and mental illness;
- 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 eliminate the stigma and discrimination faced by Canadians living with a mental illness, and their families.

4. METHOD OF OPERATION OF THE COMMISSION

To achieve its mission, the Commission will form collaborative relationships amounting to partnerships with governments, employers, mental health stakeholder organizations, treatment professionals, researchers and, in particular, those Canadians living with mental illness and their families. Such relationships will be developed with existing organizations such as the Canadian Institute of Health Information (CIHI), the Canadian Mental Health Association, the Canadian Psychiatric Association, the Canadian Mental Health Alliance, the Business Roundtable on Mental Health and Addiction, the Centre for Mental Health and Addiction, the Canadian Centre on Substance Abuse, the Public Health Agency of Canada, the F/P/T Committee on Substance Abuse, all F/P/T health departments and other relevant organizations concerned with mental health and addiction.

The coordinating functions and collaborative role of the Commission will help to reduce both duplication of effort and facilitate cooperation among all stakeholders, particularly governments and service providers.

In order to discharge its collaborative mandate, the Commission will establish, in addition to partnerships, a number of advisory committees. While it will be up to the Commission to decide on their number and composition, two advisory committees are obligatory – one composed of representatives of every F/P/T government and another of representatives from Canada's aboriginal communities.

The Commission will assist governments, employers, and service providers in a non-confrontational way, recognizing that the circumstances in which mental health policies and services are provided in every community are distinct. Yet every community can benefit from lessons learned elsewhere, especially given the linkage between the most effective mental health services and primary and community-based care – areas in which best practice information would be particularly helpful both to communities seeking to improve the effectiveness of their own services and to provincial and territorial governments.

5. ACTIVITIES OF THE COMMISSION

The Commission's activities can be divided into seven broad categories:

a) Strategic Planning

- Proposing goals relating to mental health and mental illness and a framework for a national strategic plan to achieve them, recognizing that such a plan must:
  - take into account existing federal, provincial and territorial mental health plans;
  - reflect the fact that governmental responsibility for mental health is very much inter-ministerial in nature (i.e. not confined to ministries of health);

- Providing information to governments, stakeholders and the public on mental health issues. (The attached appendix expands on the benefits of the Commission being a source of information to governments on such issues.);
- Reporting annually to the F/P/T Conference of Deputy Ministers of Health and the Deputy Ministers responsible for Social Services;
- Ensuring that the specific issues on which the Commission will focus at any given time are in accordance with the interests of its Board and its committees as they evolve over time.

b) Collaboration with Stakeholders

- Supporting the adoption of best clinical and service delivery practices;
- Promoting the integration of mental health and primary care services by, for example, disseminating information on successful collaborative models of integrated care throughout Canada and elsewhere;
- Working with employers and organizations, such as the Business Roundtable on Mental Health, Mental Illness and Addiction, to develop programs to reduce the burden of mental illness and addiction on those affected and on the economy.

c) Connecting Addiction and Mental Health Stakeholders

- Fostering greater collaboration between addiction and mental health stakeholders with a view to improving services and supports for the many individuals coping with addictions who are also living with mental illness;
- Providing information on how services for people with concurrent disorders can be most effectively and efficiently integrated;
- Disseminating provincial/territorial best practices in this area;
- Collaborating with other organizations such as the Canadian Centre on Substance Abuse.

d) Public Education and Public Awareness

- Implementing a national anti-stigma program to educate Canadians about the reality of mental illness with the ultimate goal of eliminating all forms of discrimination against people and families living with mental illness;
- Mounting targeted communications campaigns on specific aspects of mental illness (e.g. the signs of serious depression) aimed at specific target audiences (e.g. school aged children);
- Educating Canadians on ways and means of optimizing their own and their loved ones' mental health;

- Promoting population mental health and the prevention of mental illness and addiction;
- Sponsoring activities, such as conferences, seminars, and an annual awards program to celebrate people who provide exceptional leadership in mental health.

e) Knowledge Exchange

- Creating an internet-based national Knowledge Exchange Centre for the distribution of information about mental health;
- Monitoring national and international developments in mental health policies and services and, where relevant, incorporating this information into the website of the Knowledge Exchange Centre;
- Making the Knowledge Exchange Centre accessible to people living with mental illness, their families and caregivers, employers, researchers, governments and other stakeholders;
- Linking the Knowledge Exchange Centre website with relevant sites operated by provincial governments and stakeholder groups.

f) Encouraging Research

- Through the Canadian Institute of Health Information and Statistics Canada, collecting on a regular basis data on the mental health status of Canadians to provide, on the Commission's website, a comprehensive database for use by researchers and governments;
- Encouraging the Canadian Institutes of Health Research (CIHR) to support research into the best structures and/or mechanisms to supply most efficiently the wide range of services required by people living with mental illness and addiction;
- Encouraging CIHR to support research in how to measure the outcomes of mental health services so that governments can determine the success and effectiveness of their mental health programs.

g) Publishing Information

- Publishing studies, reports and other documentation on mental health;
- Developing measures against which governments can monitor the performance of their mental health systems over time;
- Developing benchmark capacity requirements for different types of services along the entire continuum of mental health services.

The Commission will both contract out projects and undertake work itself consistent with its mission on behalf of various Canadian and international institutions including both governments and non-governmental organizations in the private sector.

It is important to emphasize that the Commission is to be advisory and facilitative, *not* operational in nature.

Specifically, the Commission will *not*:

- Provide any services itself, except for its management of the Knowledge Exchange Centre and the national anti-stigma campaign, or in association with its doing work under contract for other institutions;
- Monitor the performance of any government with respect to mental health services. The Commission will recognize explicitly that each government's approach to providing mental health services must reflect the particular characteristics of that jurisdiction.

6. COMPOSITION OF THE BOARD OF THE COMMISSION

The Commission will be established under federal legislation or other appropriate authority (e.g. through incorporation as a not-for-profit corporation).

In structuring the Commission's Board, two principles must be kept in mind:

- First, as set out in the guiding principles outlined above, the Commission will operate "at arms-length both from governments and all existing mental health stakeholder organizations." Therefore no single stakeholder group, including government, should have a majority of seats on the Board;
- Second, to facilitate its effectiveness, the Board should not be too large. Adequate input from all stakeholder groups can be ensured, through the judicious use of the advisory committees (including the F/P/T governmental advisory committee and the aboriginal advisory committee specified above).

These two constraints, together with the precedents established by the composition of the Boards of the Canadian Institute for Health Information and the Canadian Patient Safety Institute, lead the Committee to recommend 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.

Therefore the Board of the Commission will consist of:

a) Five provincial governmental nominees chosen as follows:
   - One from the Atlantic provinces, one from Quebec, one from Ontario, and two from the Western provinces.

b) One member nominated jointly by the three territorial governments.

c) One member nominated by the federal government.

d) Eleven nominees at-large chosen by the seven government nominees to represent a wide range of stakeholders involved in mental health issues, including those living with mental illness, their families, caregivers, service providers, the professions, employers etc. No nominee can represent a specific organization; each must be widely considered to reflect the mental health community at large.

e) A non-governmental chair (the Canadian Mental Health Commissioner) chosen by the seven government nominees.

Board members will serve three year terms and be eligible for renewal once. All, including the Commissioner, will be part-time.

7. STAFF OF THE COMMISSION

The full-time staff of the Commission, initially consisting of 25 to 30 people, will be under the direction of an Executive Director.

8. FUNDING FOR THE COMMISSION

All funding (the amount of which is currently under study by the Senate Committee) will be provided by the federal government. The budget will consist of:

- Core funding for the Commission's Board, staff, and operations;
- Funding "earmarked" for establishment and management of the Knowledge Exchange Centre;
- Funding "earmarked" for public education and anti-stigma and other communications campaigns.

APPENDIX

Every government faces myriad issues as it attempts to improve services to people living with mental illness. While some of these issues are specific to a jurisdiction, many others are broadly applicable across jurisdictions. It is with respect to the latter that the Commission can play a valuable role for all governments by providing information on what has proven to be most effective in other provinces and other countries (i.e. best practices), sparing each government from having to gather and assess the information on its own.

Four such issues illustrate the point:

a) Strategic Investment Decisions

To plan effectively for the transformation of the mental health service delivery system across the continuum of provincial, regional and community based services, it is critical that governments have available evidence-based information with respect to the most effective practices elsewhere in Canada and in other industrialized countries. In the absence of such information, governments have little defence against pressures to adopt particular policies and practices based only on anecdotal evidence or that represent flavour-of-the-month fads.

Having collected and evaluated practices used elsewhere, the Commission will provide leadership in building a natural consensus around best practices.

b) Primary Care and Community Based Service Delivery

Experiments in new ways of integrating mental health services into multidisciplinary primary care clinics and of delivering community based services are taking place across the country. Evaluation of the effectiveness of these experiments and developing a comparison of evidence-based best practices will be very useful to governments and service providers alike.

c) Chronic Mental Illness

People living with a chronic mental illness need a range of services, many of which (social housing, for example, and various types of income support and training programs) are not provided by health departments. Given that they are usually the responsibility of different government departments, often governments lack a mechanism to coordinate the range of services needed by a single consumer. Because no single department "owns" or has sole responsibility for a person living with a mental illness, even an aggressive case manager – clearly part of the solution to the problem – will have difficulty crossing departmental lines. That some of these services, social housing for

example, have fallen out of political favour in recent years makes solving the problem even more difficult.

The Commission will help governments in two ways:

- First, by evaluating mechanisms which have been used elsewhere to coordinate effectively multi-department services for a single consumer and proposing options for governments to consider.
- Second, by identifying gaps in the services required and encouraging governments to fill them.

d) Mental Health Human Resources

It is widely acknowledged that a severe shortage of mental health human resources exists across the whole spectrum of mental health service providers. It is also acknowledged that existing training programs (and programs designed to update the skills of people currently working in the field) need modification.

For example:

- Few people are trained in how to help those who suffer from concurrent disorders. Often someone with both a mental illness and an addiction is treated sequentially; the treatment is frequently ineffective because the problems are linked. The solution to this problem requires significant change in the training of mental health workers.
- Nurse practitioners and nurses need more training in how to help people living with a mental illness and how to identify the presence of concurrent disorders. This requires changes in academic curricula, always a very slow and difficult thing to achieve. Family members also need training of the same kind but in community settings.
- Scope of practice rules require modification if multi-disciplinary primary care clinics are to become the predominant point of entry into a transformed mental health system. There is bound to be resistance to such changes.
- Assessment of the skill set required to provide various mental health services will enable accurate forecasts to be made of the numbers of mental health workers of different categories required in Canada in the future.

By providing an informed, authoritative source of national pressure, equally independent of government, advocacy groups, service providers, and those responsible for providing training and education programs for mental health workers, the Commission will reinforce governments as they seek changes of the kind described above.