

PART V

Federal Leadership

CHAPTER 13: THE FEDERAL DIRECT ROLE

...initiate and coordinate activity across all federal departments to address federal government responsibilities to specific populations under its direct jurisdiction. —Dr. Albert Schumacher, President, Canadian Medical Association¹

The federal government has significant responsibility for programs and services related to the mental health of seven client groups. For each group, this chapter provides an extensive description of the source of the federal authority and the array of federal programs and services for mental health, mental illness and addiction that are in place. It then offers some assessment of the needs of each group and a commentary about each situation.

To the best of the Committee's knowledge, this is the first time a comprehensive look at the mental health needs of all the federal client groups has been undertaken. Therefore, following its examination of each client group, the Committee reviews the broader implications of the federal government's addressing the mental health concerns of the more than one million Canadians who are its clients. In this chapter's concluding section, the Committee identifies components of an integrated approach to improving mental health outcomes for all federal client groups.

To facilitate reading this long chapter, the following table provides a brief snapshot of the contents of each section pertaining to specific client groups. It presents a summary overview identifying the particular client groups, the responsible federal departments, and the general mental health activities undertaken by them.

Table 1: Federal Client Groups in Summary

Client Groups	Federal Departments	General Mental Health Activities
First Nations and Inuit (13.1)	Health Canada	Community-based mental health care for First Nations on-reserve; Non-insured drugs and short-term mental health crisis counseling for registered First Nations and recognized Inuit; Addiction treatment centres.
	Indian and Northern Affairs Canada	Basic services for First Nations on-reserve and in Inuit communities including education, income assistance, housing, family violence prevention.

¹ 20 April, 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Client Groups	Federal Departments	General Mental Health Activities
Federal Offenders (13.2)	Correctional Service Canada	Basic mental health nursing assessment at reception centres; admission to treatment centres if necessary and available; general services at regular institutions; essential services if in Community Correctional Centre; non-insured health care coverage if approved.
Canadian Forces (13.3)	National Defence	Non-emergency, outpatient mental health through base clinics, health care centres and support units; Specialized mental health services purchased from provinces; Referrals to operational trauma and stress support centres.
Veterans (13.4)	Veterans Affairs Canada	Community based mental health care services extending beyond provincial or territorial plans; Institutional mental health care in Ste-Anne-de-Bellevue, Quebec and in contract hospitals in provinces; Shared services with DND on operational trauma and stress.
RCMP (13.5)	RCMP	General health services offered within regional divisions to ensure fitness to perform duties; Use of provincial services as authorized.
Immigrants and Refugees (13.6)	Citizenship and Immigration Canada	Essential and emergency mental health services (physician, hospital, and drug) for those unable to pay.
Federal Public Service Employees (13.7)	Treasury Board	Coverage of services and other benefits not provided through provincial/territorial insurance plans; Employee assistance counseling.

From the outset, the Committee emphasizes that it expects the federal government, together with its provincial and territorial counterparts, to ensure that federal clients have access to the system transformations already identified in Chapter 5. Thus, the Committee intends First Nations and Inuit, federal offenders, Canadian Forces members, veterans, RCMP members, immigrants and refugees and federal public service employees to be part of a mental health system that is recovery-oriented, person-centred, community based, and integrated across the full continuum of care and all age groups.

The Committee is pleased with the significant evidence that individual federal departments and agencies have moved in this direction. Some departments have developed approaches that utilize case management and a wider range of mental health providers. Others have focused on mental health enhancements through improvements to the determinants of mental health such as housing, employment and broad social needs. Several departments and agencies are working collaboratively with one another and with their provincial and territorial counterparts on mental health initiatives.

13.1 FIRST NATIONS AND INUIT

*Inuit have embraced the federal commitment to a renewed relationship and believe that a further commitment for an Inuit-specific mental health strategy is important. —Larry Gordon, Chairman, National Inuit Committee on Health, Health Department, Inuit Tapiriit Kanatami*²

*A collaborative action plan and wellness strategy between federal and First Nations leadership would immediately address the mental wellness crisis in a manner that is collaborative, comprehensive and culturally relevant. —Valerie Gideon, Director of Health and Social Secretariat, Assembly of First Nations*³

13.1.1 Federal Responsibility

Under the *Constitution Act, 1867*, section 91(24) allocated exclusive legislative responsibility over “Indians and Lands reserved for the Indians” to the federal Parliament. In turn, Parliament passed the *Indian Act* of 1876 that established the criteria for a “status Indian” together with a framework for federal jurisdictional responsibilities. A ruling of the Supreme Court in 1939 further determined that Inuit (then called Eskimos) were Indians for the purposes of section 91(24).⁴

It is important to note that this section looks only at the First Nations and Inuit clients who are identified primarily as federal clients. The federal government does *not* acknowledge responsibility for all Aboriginal peoples; it is estimated that one-third of Aboriginal peoples do not have specific access to federal programs and services. At the present time, the federal government provides certain federal programs and services to status Indians (also known as Registered Indians and First Nations) that are not available to non-status Indians or to Métis. In addition, some but not all federal programs and services have been extended to Inuit.

This chapter considers only the First Nation and Inuit considered eligible for federal programs and services relevant to mental health, the main focus being on those delivered through the departments of Health Canada and Indian and Northern Affairs. The following chapter (Chapter 14) provides a broader perspective in that it covers the mental health of all Aboriginal peoples, including non-status (and off-reserve status Indians) as well as Métis. Chapter 14 also presents the components for a comprehensive, integrated, community-based

² 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

³ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁴ *Indian Act*, R.S. 1985, c. I-5, <http://laws.justice.gc.ca/en/I-5/>, Tonina Simeone, *Federal-Provincial Jurisdiction and Aboriginal Peoples*, TIPS-88E, Library of Parliament, 2001. Mary Hurley, *The Indian Act*, TIPS-17, Library of Parliament, 2004, <http://lpintrabp.parl.gc.ca/apps/tips/printable/tip17-e.pdf>.

wellness and healing strategy that supports distinct approaches for all groups of Aboriginal peoples.

Indian and Northern Affairs Canada has primary responsibility for the constitutional and statutory obligations and responsibilities of the federal government to Indian and Inuit people. Through the administration of the *Indian Act*, the department supports self-government, economic, educational, cultural, social, and community development for registered Indians and certain Inuit. According to the departmental performance report of 31 March 2005, the total Status Indian population was 733,626.⁵ The report provides no indication of the size of the Inuit population.

Health Canada has primary federal responsibility for health services, including mental health services, to First Nations and Inuit on all reserves and in many remote and isolated communities; it delivers these services through nursing stations and health centres. In addition, the 2005 departmental performance report indicated that Health Canada provides “supplementary health benefits to approximately 765,000 eligible First Nations and Inuit people.”⁶

Health Canada has primary federal responsibility for health services, including mental health services, to First Nations and Inuit on all reserves and in many remote and isolated communities; it delivers these services through nursing stations and health centres.

Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch, Health Canada described the agreement on Federal Indian Health Policy signed in 1979 that defines the current roles of the federal and provincial governments.⁷

The division of mental health responsibilities between the federal health department and its provincial or territorial counterparts is “often confusing, even for those of us who are in this on a day-to-day basis.”

It meant that on isolated reserves and areas where provinces were not providing primary care, the federal government would continue to finance and provide that. It meant that the federal government would provide public health services on all reserves, including prevention services. As well, it meant that the federal government would provide non-insured drugs, dental work and transportation for all First Nations and Inuit on and off-reserve.⁸

Mr. Potter acknowledged that the division of mental health responsibilities between the federal health department and its provincial or territorial counterparts is “often confusing, even for those of us who are in this on a day-to-day basis.” He nonetheless offered the following capsule description:

⁵ Indian Affairs and Northern Development Canada, *Performance Report for the period ending March 31, 2005*, p. 21, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/INAC-AINC/INAC-AINCd45_e.pdf.

⁶ Health Canada, *Performance Report for the period ending March 31, 2005*, p. 6, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/HLTH-SANT/HLTH-SANTd45_e.pdf.

⁷ Health Canada, *Federal Indian Health Policy 1979*, http://www.hc-sc.gc.ca/fnih-spni/services/indi_health-sante_poli_e.html.

⁸ 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Basic mental health services and addiction services are provided primarily by provincial governments to all residents of the province, which includes First Nation, Inuit and other Aboriginal people. They provide hospital care, psychiatric and general physician services. Provinces also provide community-based prevention, outpatient treatments, aftercare, detoxification services and residential addiction treatment services.⁹

13.1.2 Federal Programs and Services

Indian and Northern Affairs Canada and Health Canada have increasingly delegated to First Nations authorities and some Inuit communities their departmental responsibility for the administration and delivery of many programs and services vital for mental health. Specific eligibility criteria still apply to these programs regardless of who provides them:

Within the federal jurisdiction, Indian and Northern Affairs Canada has the widest scope of programs and services related to the broad determinants of mental health. It offers services to First Nations on reserves that are similar to those delivered by provinces to their general populations.

- Indians must be registered as an Indian under the *Indian Act* and be recorded on the Indian Register; Inuit have a recipient identification number.
- For some services, prior approval is required from departmental authorities.
- The programs serve eligible individuals resident or ordinarily resident on a reserve or in a recognized Inuit community.

Within the federal jurisdiction, Indian and Northern Affairs Canada has the widest scope of programs and services related to the broad determinants of mental health. It offers services to First Nations on reserves that are similar to those delivered by provinces to their general populations. These services include education, income assistance, and infrastructure support and account for more than 80 percent of total on-reserve funding.

Indian and Northern Affairs Canada's Elementary/Secondary Education Program provides access to schools, either by funding instructional services on reserves, or by covering the cost of attending provincial or territorial schools. Its Social Assistance Program helps First Nations individuals and families living on reserves meet basic needs for food, clothing and shelter. Its Family Violence Prevention Program funds some shelters on-reserve, reimburses shelters located off-reserve for services provided to First Nations people who ordinarily live on a reserve and also funds community-based family violence prevention programs.

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⁹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

\$267.5 million. This included \$36.4 million in 2004/2005 spent through the Non-Insured Health Benefits Program on pharmaceuticals to treat mental illness and addiction.¹⁰

The estimate also included community-based prevention and promotion programs on reserves and in Inuit communities:

... \$40 million a year in ongoing funding to community-based mental health programs through a program called Building Healthy Communities, and an additional \$51 million per year for mental health and child development activities through Brighter Futures.

In addition, addiction programs were provided to First Nations and Inuit organizations through

... the National Native Alcohol and Drug Abuse Program (\$59 million per year), the Youth Solvent Abuse Program (\$11 million per year), the First Nations and Inuit Tobacco Control Strategy (\$12 million per year), and the Canadian Drug Strategy (\$1 million per year).¹¹

Mental health counselling, usually provided by psychologists, was available through the Non-Insured Health Benefits program to eligible First Nations and Inuit regardless of residency. Kathryn Langlois, Director General, Community Programs Directorate, First Nations and Inuit Health Branch, Health Canada, emphasized that federal provision was limited to short-term counselling:

We would provide the short-term crisis mental health counselling and then a referral would be made to the provincial system. It would be accessed in the same way as any individual off-reserve, through emergency or a family physician. The province would pay.¹²

Kathryn Langlois also referred to substantial departmental work on suicide that was begun after a suicide prevention advisory group was set up in 2002 by then National Chief Matthew Coon Come and Health Minister Alan Rock. New funding announced in September 2004 included \$65 million allocated over five years for an Aboriginal youth suicide prevention strategy; \$5 million was allocated for 2005 and \$15 million for each of the next four years.

Health Canada has also convened a First Nations and Inuit Mental Wellness Advisory Committee (MWAC) to develop a strategic action plan to improve mental wellness outcomes for First Nations and Inuit.

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¹⁰ Correspondence from Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch, Health Canada to Senator Michael Kirby, Chair, Standing Committee on Social Affairs, Science and Technology, The Senate, 7 September, 2005.

¹¹ 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹² 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

outcomes for First Nations and Inuit. The committee includes representatives from the Assembly of First Nations, Inuit Tapiriit Kanatami, Federal/Provincial/Territorial networks, mainstream and Aboriginal expert mental health and addictions organizations, Indian and Northern Affairs Canada, and the Public Health Agency of Canada. Following a strategic planning session with content experts in November 2005, a draft plan was made available for the committee's review in February 2006.¹³

13.1.3 Assessments of Client Group Needs

The registered Indians and recognized Inuit that make up the defined federal client group have a very diverse set of characteristics. For example, while the services and programs are available primarily for First Nations living on-reserve, many individuals migrate in and out regularly. Some Inuit live within the area covered by land claims agreements while others do not.

Overall, these clients have poor health status, "well below that of the rest of Canadians".

Overall, these clients have poor health status, "well below that of the rest of Canadians."¹⁴ Furthermore, providing services to them is made more difficult due to their geographic dispersal across wide areas; many live in remote or isolated communities.

13.1.3.1 Indian and Northern Affairs Canada's Programs and Services

Indian and Northern Affairs Canada has responsibility for several key factors that are essential to a comprehensive approach to the mental health of First Nations and Inuit communities, factors such as economic development, housing and education. Witnesses told the Committee that the Department's efforts fell short of expectations. Irene Linklater, Research Director, Research and Policy Development Unit, Assembly of Manitoba Chiefs criticized the fact that:

... the Department of Indian Affairs spends 13 million on social assistance to every \$1.00 in economic development. The impact has been that Manitoba First Nations communities have at least one-third to one-half of the First Nations on-reserve population on income assistance, with a range of 24 to 88% in some communities.¹⁵

Witnesses also made a connection between serious housing inadequacies and the resulting negative effects on mental health:

¹³ Correspondence from Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch, Health Canada to Senator Michael Kirby, Chair, Standing Committee on Social Affairs, Science and Technology, The Senate, 7 February 2006, p. 2.

¹⁴ Health Council of Canada, *The Health Status of Canada's First Nations, Inuit and Métis*, January 2005, <http://healthcouncilcanada.ca.c9.previewyoursite.com/docs/papers/2005/BkgrdHealthyCdnsENG.pdf>.

¹⁵ According to Linklater, the statistic was from research conducted by the Assembly of Manitoba Chief in 2001; 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

The experience of what is considered homelessness and what we see as invisible homelessness is that by living in such crowded conditions, there is a constant moving of people and houses, and they are not found within the statistics; in other words, you do not see that reflected within a statistical framework. Lack of proper housing is associated also — and research studies confirm this — with lack of personal care, ill health, and lower longevity. — Irene Linklater¹⁶

A federal housing program in the Arctic Inuit regions would not only resolve the housing shortages, but it would also alleviate some of the social problems such as family violence and addictions. — Larry Gordon¹⁷

Donna Lyon from the National Aboriginal Health Organization talked about limits on post-secondary education support, particularly the difficulties of accessing funding from departmental sources. She also suggested that, even when resources are available, they may be insufficient to sustain a student with a dependent family:

... you have many people who cannot access funding, and when they do, sometimes a living allowance is provided, which is often not adequate. You have families living on maybe \$1,100 a month...¹⁸

Larry Gordon pointed to the lack of infrastructure and employment in the north for educated Inuit who want to return and contribute to their communities:

Many times when people leave the North and come back, there is no work for them. They have received an education and a degree, but there is no work for them. They become engineers. The only work that they can actually do is in the South because of their training and background.¹⁹

13.1.3.2 Health Canada's Programs and Services

Despite some progress in health funding agreements over the past year, witnesses criticized Health Canada's funding arrangements as being complicated, short-term and insufficient to meet the mental health needs of the population.

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¹⁶ 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁷ 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁸ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁹ 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

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Irene Linklater noted that, for First Nations, health transfers for mental health programs on-reserve were inflexible, confusing and inadequate:

Sometimes the feds flow the money to the province, and the province holds money on a per capita basis for First Nations based on First Nations population in the region. Some of the services that First Nations receive come directly from First Nations and Inuit health branch contribution agreements. [...] Depending on the types and range of services, sometimes the province will enter into an arrangement with a First Nation for specific health cost.²⁰

Onalee Randell, Director of Health, Inuit Tapiriit Kanatami, explained that, for the Inuit, the short-term, unstable and uncertain funding presents significant barriers to the delivery of mental wellness programs:

The short-term, unstable and uncertain funding presents significant barriers to the delivery of mental wellness programs.

By the time initiatives with three- to five-year timelines are operational in communities, the funding has run out. It is hard to get qualified staff to give up permanent jobs to go into a project that may end in two years.²¹

Even the Non-Insured Health Benefits Program fell short of meeting the needs of the targeted populations. Ms Randall indicated that an analysis of 2003-04 financial expenditures on the crisis intervention component of the non-insured health benefits for Inuit found:

Addiction-related programs and services such as the National Native Alcohol and Drug Addictions Program are affected by policies for health transfers that do not allow for unanticipated population growth or for the complex nature of existing needs.

... approximately \$60,000 of that program was spent on mental health for Inuit communities: \$60,000 for communities that have up to 11 times the national average for suicide. There seems to be an inequity. The program is designed to provide short-term crisis counselling. In some of the communities there are no counsellors who can provide that short-term crisis counselling, and in many cases the communities choose not to access the short-term [intervention services]. People come in after a suicide, they spend three days in the community, and then they leave.²²

²⁰ 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²¹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²² 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Lorraine Boucher told the Committee that, for First Nations clients with mental health or addiction problems who must travel to access mental health services outside their remote communities, the Non-Insured Health Benefits Program was inadequate:

Some of our members have had to stop counselling sessions because of government cutbacks, such as medical transportation cutbacks, and those people are lost in the system. The cost to travel to Edmonton or Peace River is too heavy a burden for them to carry without assistance.²³

Irene Linklater also explained how addiction-related programs and services such as the National Native Alcohol and Drug Addictions Program are affected by policies for health transfers that do not allow for unanticipated population growth or for the complex nature of existing needs:

For Inuit trying to access addiction services, a barrier is created by the regional administrative divisions established within Health Canada.

... the National Native Alcohol and Drug Addictions Program has not kept pace with the community needs, due to the expectations to intervene on family issues such as family violence, suicide attempts, individual crisis, to provide support and aftercare to those returning from treatment, and a community-wide support following tragedies.²⁴

According to Onalee Randell, for Inuit trying to access addiction services, a barrier is created by the regional administrative divisions established within Health Canada:

The Inuit in Nunatsiavut want to work with the Inuit in Nunavik to develop an addictions program based on the Inuit culture and values. Right now, it is difficult to share that information and the resources because of where those jurisdictions get their federal dollars from. The Inuit in Nunatsiavut get it from Atlantic Region, and the Inuit in Nunavik get it from Quebec region, and never the two shall meet.²⁵

13.1.3.3 Departmental and Jurisdictional Confusion

In addition to interdepartmental barriers, First Nations and Inuit clients frequently experience difficulties because responsibilities cut across federal departments. Such cross-jurisdictional barriers between federal and provincial or territorial governments prevent forward movement on mental health concerns.

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²³ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁴ 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁵ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Shawn Atleo, Chief A-in-chut, B.C. Regional Chief, Assembly of First Nations, commented on the lack of a departmental focal point at the federal level, noting that he had talked to three different deputies from three different departments over the previous week about housing.²⁶ Jennifer Dickson, Executive Director, Pauktuutit Inuit Women's Association, told the Committee that she was obliged to deal with six independent federal departments on a weekly basis for various programs, policy and projects.²⁷

Jules Picard, Social Services Coordinator, First Nations of Quebec and Labrador Health and Social Services Commission told of a cross-jurisdictional situation that involved a young person with schizophrenia who was in trouble with the law and needed medication. A setback occurred when it was determined that "Health Canada cannot pay for that young person's medication because he is the responsibility of the provincial prison system."²⁸

There is enormous uncertainty when people seek financial resources for services and try to determine whether Indian Affairs, Health Canada or the province has responsibility for payment.

Susan Levi-Peters, Chief of Elsipogtog First Nation, New Brunswick, described the enormous uncertainty when people seek financial resources for services and try to determine whether Indian Affairs, Health Canada or the province has responsibility for payment.

*When we go to the provincial level, the province tells us it is not our responsibility, it is the federal government. We go to the federal government and they tell us, "We give the money to the province, go to the province." We are the people who are in limbo.*²⁹

Ian Potter emphasized that there is currently a focus among governments on cross-jurisdictional integration:

*The integration of the federal services with provincial services would reduce duplicative services or incidence of services that do not fit together. Service would then be truly focused on the needs of the patient so that the system is clear and not broken up by jurisdictional differences.*³⁰

However, Valérie Gideon, Director of Health and Social Development, Assembly of First Nations, expressed concern over such integration:

²⁶ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁷ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁸ 21 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/23evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

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

³⁰ 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

*It is our opinion that this could be misconstrued as an off-loading of federal responsibility, certainly something that has often been communicated to us by our regions and our communities.*³¹

Ian Potter also noted the need for cross-departmental integration within the federal government between Health Canada and Indian and Northern Affairs Canada. For example, to increase Aboriginal health human resources, he argued that existing bursaries and scholarships for professional medical programs must be connected to educational programs earlier in the system that are overseen by Indian and Northern Affairs Canada, “starting in grade school, so that Aboriginal people see this as a realistic opportunity.”

The Auditor General of Canada has repeatedly criticized Health Canada and Indian and Northern Affairs Canada for not having clearly established legislative authority for programs and services directed to First Nations and Inuit. In particular the Auditor General has noted that the absence of specific enabling legislation for the Non-Insured Health Benefits program “left a gap in the definitions of purpose, expected results and outcomes of program benefits.” Health Canada was urged to seek “a renewed mandate for the program to clarify the authority base, purpose and objective of the program.”³²

The Auditor General also pointed out that, although the *Indian Act* sets out requirements for determining who is a “status Indian” and detailing federal jurisdiction over them collectively, it does not specify the programs and services to be provided. Both Indian and Northern Affairs Canada and Parliament were reminded that:

*The lack of substantive legislative authority could undermine parliamentary control and accountability. It precludes parliamentary debate on important questions such as whether a social assistance program for on-reserve Indians should address reducing the demand for services in addition to supplying the services, and what the appropriate benefits ought to be. In addition, it does not provide an instrument for Parliament to hold the Department accountable against program authorities, beyond those approved by the Treasury Board.*³³

13.1.4 Committee Commentary

As noted earlier, in the following chapter (Chapter 14), the Committee addresses the need for a comprehensive approach to the mental health of all Aboriginal peoples. There, we emphasize the significance of the proposed creation of a National Aboriginal Advisory Committee as part of the Canadian Mental Health Commission. We also point to the need for more transparent reporting of actions via a federal interdepartmental committee of the deputy ministers responsible for all programs and services for all Aboriginal peoples.

³¹ 21 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/23evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

³² Auditor General of Canada, *Health Canada — First Nations Health*, Chapter 13, October, 1997, <http://www.oag-bvg.gc.ca/domino/reports.nsf/html/ch9713e.html#0.2.L39QK2.4FNW9F.4QDJQE.ZG>.

³³ Auditor General of Canada, *Indian and Northern Affairs Canada — Social Assistance*, 1994, <http://www.oag-bvg.gc.ca/domino/reports.nsf/html/9423ce.html#0.2.L39QK2.6NA0GI.V1SJQE.ZL>.

The *Blueprint for Aboriginal Health* document tabled at the First Ministers' Meeting of November 2005 reiterated previous commitments to clarify issues related to the respective roles and responsibilities of federal, provincial and territorial governments.³⁴ However, First Nations and Inuit clients have a particular historical relationship with the federal government and their multi-dimensional concerns require specific attention through federal institutional avenues. The Committee is acutely aware that, while some past and current federal initiatives have targeted the mental health of First Nations and Inuit, the ongoing expenditures for federal programs and services have not created the anticipated positive outcomes. The Committee perceives a huge gap between the financial commitments of the federal government and concrete results of benefit to First Nations and Inuit people.

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The Committee believes that some forum for objective oversight is needed with respect to the mental health of First Nations and Inuit, an independent mechanism that would function like an ombudsman. It should be able to undertake investigations to hold the federal government accountable for providing appropriate and adequate programs and services and for the results they achieve.

Other federal client groups such as federal offenders, Canadian Forces and RCMP members already have access to an entity that will systematically investigate, recommend and ensure appropriate responses to their concerns. First Nations and Inuit clients need a comparable specific avenue of redress when interacting with federal departments that have a major impact on their mental as well as their physical health.

The Committee therefore recommends:

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- 69 **That the federal government establish a federal entity for First Nations and Inuit clients, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee;**
- That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of First Nations and Inuit;**

³⁴ Health Canada, *Blueprint on Aboriginal Health: A 10-Year Transformative Plan*, Prepared for the Meeting of First Ministers and Leaders of National Aboriginal Organizations, 24-25 November 2005, a Work in Progress, 2005, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2005-blueprint-plan-abor-auto/plan_e.pdf.

That the person responsible for this entity be, if possible, of aboriginal origin;

That this entity provide an annual report to Parliament.

The Committee was dismayed to note that, under the 2005 *Blueprint on Aboriginal Health*, detailed reporting on the combined outcomes of federal and provincial programs and expenditures on the health of First Nations, Inuit, and Métis peoples will not take place until 2010-2011.³⁵ At present, the data from Indian and Northern Affairs Canada and Health Canada is limited and is focused primarily on First Nations. For example, spending information uses the combined term of 'First Nations and Inuit' and does not identify the amounts of money spent on each group; the implication is that spending is proportional to the size of each group's population. There is no reliable evidence useful for developing and evaluating programs and services for Inuit given that the data are merged with those of First Nations or other Aboriginal groups.

The Committee was dismayed to note that, under the 2005 *Blueprint on Aboriginal Health*, detailed reporting on the combined outcomes of federal and provincial programs and expenditures on the health of First Nations, Inuit, and Métis peoples will not take place until 2010-2011.

There is no reliable evidence useful for developing and evaluating programs and services for Inuit given that the data are merged with those of First Nations or other Aboriginal groups.

Although the federal government has pledged to develop comprehensive reporting based on distinct health indicators for each Aboriginal group, the Committee is concerned that Parliament and departments will continue to make decisions over the next five years without access to full information.

Thus, the Committee recommends:

70 **That Indian and Northern Affairs Canada, Health Canada and any other departments with direct program and service responsibility for First Nations and Inuit clients develop an annual inventory of their respective programs and services currently and for the last five years.**

That the inventory include a clear description of: each program or service by fiscal year; the criteria for eligibility; the number of First Nations and Inuit clients respectively served by the program by geographical location; the amount of funding allocated and the amount spent; and any evaluation of outcomes related to the determinants of mental health.

That the inventory be reported to Parliament annually starting in 2008.

³⁵ *Ibid.*

Most importantly, the Committee believes that the current configuration of federal departments with their respective legislative or policy bases are not now promoting positive change for First Nations and Inuit. Since the initial transfer of the control and administration of medical services for Indians and Inuit from the Department of Indian Affairs to the Department of National Health and Welfare in 1945, there has been little improvement in the health status of this population. The federal government has had ample time to clarify its own role and responsibilities through legislation and to develop policies to reduce interdepartmental confusion. It is time to take significant steps to rectify the interdepartmental fragmentation that contributes to the overall poor health status of First Nations and Inuit.

The federal government has had ample time to clarify its own role and responsibilities through legislation and to develop policies to reduce interdepartmental confusion. It is time to take significant steps to rectify the interdepartmental fragmentation that contributes to the overall poor health status of First Nations and Inuit.

The Committee believes strongly that a comprehensive population health approach is essential to reinforce mental health among First Nations and Inuit. The separation of programs and services between Health Canada and Indian and Northern Affairs Canada does not make sense. The Committee believes the services currently offered by Indian and Northern Affairs Canada for housing, education, and income support must be connected to services offered by Health Canada related to the promotion of healthy child development and of coping skills aimed at reducing addiction and suicide. At present, these programs and services are uncoordinated and the departments compete for budget allocations. A dramatic change is needed to ensure that First Nations and Inuit receive an inclusive range of programs and services related to health determinants and linked to positive outcomes. The change must be real transformation of the existing situation, not simply a minor adjustment.

The Committee believes the services currently offered by Indian and Northern Affairs Canada for housing, education, and income support must be connected to services offered by Health Canada related to the promotion of healthy child development and of coping skills aimed at reducing addiction and suicide.

The Committee realizes, however, that any change in the delivery of programs and services that incorporates a clear legislative base requires full consideration of the potential options and their implications. Thus, the Committee recommends that the federal government conduct an objective and independent examination into the best way to provide programs and services crucial for the promotion and maintenance of the health of First Nations and Inuit, with careful thought to the requisite legislation. At this point, the Committee cannot say with certainty which of the following options would be the best approach:

- Should the current structures be maintained with significant modifications to the way that Health Canada and Indian and Northern Affairs Canada deliver programs and services;
- Should the responsibilities of Health Canada's First Nations and Inuit Branch be transferred to Indian and Northern Affairs Canada; or

- Should specific resources be transferred, with appropriate accountability and evaluation criteria, to either First Nations (and Inuit) authorities or to provincial (and territorial) governments?

The Committee recommends:

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

...incarcerating mentally ill people in jails and prisons is cruel, unjust and ineffective. Prisons do not have adequate or appropriate facilities, resources or medical care to deal with the mentally ill. Poorly trained staff is unable to handle the difficulties of mental illness. The mentally ill suffer from illogical thinking, delusions, auditory hallucinations, paranoia and severe mood swings; they do not always comprehend the rules of jails and prisons. They are highly vulnerable and prone to bizarre behaviour that prison staff must deal with and inmates must tolerate. —Bonita Allen, mother of bipolar son³⁶

13.2.1 Federal Responsibility

Correctional Service Canada (CSC) is responsible for administering sentences imposed by the courts that are two years or longer. The *Canada Health Act* explicitly excludes “a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*” from the definition of insured persons covered under provincial health care plans.³⁷ The federal government is directly responsible for the provision of health care services to inmates in federal institutions.

A comparison between admissions to federal institutions in 1967 and then again in March 2004 indicates that there has been a 60% increase in the number of offenders with mental disorders.

— *Howard Sapers*

Almost half of those with substance abuse problems have another concomitant disorder; the rate of suicide is considerably higher among inmates than in the general population.

In 1992, the *Corrections and Conditional Release Act* (CCRA) replaced the *Penitentiary Act*. The CCRA defines “mental health care” and requires

³⁶ 6 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/18eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

³⁷ *Canada Health Act*, 1984, Chapter C-6, Section 2 — Interpretation, <http://laws.justice.gc.ca/en/C-6/17077.html#rid-17084>.

the provision of essential health care, and “reasonable access to non-essential mental health care that will contribute to the inmate’s rehabilitation and successful reintegration into the community.”³⁸ A Commissioner’s Directive on Health Services indicates that essential health services include the provision of both acute and long-term mental health care services.³⁹ The legislation also requires consideration of “an offender’s state of health and health care needs” when decisions are made relating to placement, transfer, administrative segregation and disciplinary matters as well as in preparing for release and during supervision.

The CSC departmental performance report for the period ending March 2005 states:

On any given day in 2004/05, CSC was responsible for approximately 12,600 offenders in federal custody and approximately 8,200 offenders serving part of their sentence in the community under supervision.⁴⁰

Francoise Bouchard, Director General, Health Services, Correctional Service of Canada, reported that a high percentage of offenders have mental health problems.

About 22% of adult offenders would likely be diagnosed with FASD.

— **Howard Sapers**

Twelve percent suffer from a serious mental disorder which requires immediate intervention. The percentage of offenders with the diagnosis of mental disorder on admission has risen 61% in seven years, and during the same period the number of offenders on prescribed medication has increased by 80%.⁴¹

Howard Sapers, Correctional Investigator of Canada, mandated by the *Corrections and Conditional Release Act* to act as an Ombudsman for federal offenders, reiterated the high prevalence rates of mental illness and addiction problems among inmates:

A comparison between admissions to federal institutions in 1967 and then again in March 2004 indicates that there has been a 60% increase in the number of offenders with mental disorders. It breaks down as follows: 57% for male and 65% for female. The prevalence increases to nearly 84% if we include substance abuse in those figures.⁴²

Almost half of those with substance abuse problems have another concomitant disorder; the rate of suicide is considerably higher among inmates than in the general population. With respect to Foetal Alcohol Spectrum Disorder, Howard Sapers reported that “data obtained

³⁸ *Corrections and Conditional Release Act*, 1992, c. 20, <http://laws.justice.gc.ca/en/C-44.6/>.

³⁹ Correctional Service Canada, *Commissioner’s Directive*, “Health Services,” Number 800, 2004, http://www.csc-scc.gc.ca/text/plcy/cdshtm/800-cde_e.shtml.

⁴⁰ Correctional Service Canada, *Performance Report for the period ending March 31, 2005*, p. 12, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/CSC-SCC/CSC-SCCd45_e.pdf.

⁴¹ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁴² 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

from youth facilities across Canada estimate that about 22% of adult offenders would likely be diagnosed with FASD.”⁴³

13.2.2 Federal Programs and Services

Correctional Service Canada differentiates between ongoing correctional programs for general offenders who are not living with a mental illness, and specific programs for those in need of mental health services for such conditions as anti-social personality behaviour.⁴⁴

While the current capacity to assess and address mental health problems of offenders is limited, CSC is developing a continuum of care encompassing four key areas:⁴⁵

- mental health assessment of offenders on arrival to establish treatment plans, facility placement, and data collection for future planning;
- regional treatment centres (five currently exist) with consistent hospital status, accreditation, number and types of staff, admission criteria and security requirements; which identify clientele (such as those with FASD and personality disorders diagnoses) who need specific treatment interventions;
- regular mental health services in institutions, as well as some institutional intermediate-care mental health units to accommodate and serve those who need more structure and support but not hospitalization;
- community mental health strategy to provide continuity of care to offenders when released, including the development and implementation of specialized services and supports to address employment, accommodation, and particular mental health needs.

The *Mental health Strategy*, approved by the CSC in the summer of 2004, has languished.

In November 2005, the Annual Report of the Correctional Investigator called for Correctional Service Canada to commit adequate funding to its *Mental Health Strategy*:

The Strategy, approved by the CSC in the summer of 2004, has languished. No funding has been committed for the three front-end components of the plan: comprehensive clinical intake assessment; improvement to the Service’s current Treatment Centres; and intermediate mental health-care units within existing penitentiaries to provide ongoing treatment and assessment during the period of incarceration. Funding secured for the fourth component,

⁴³ 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁴⁴ For additional material on mental health, see Dr. Brent Moloughney, “A Health Care Needs Assessment of Federal Inmates in Canada,” *Canadian Journal of Public Health*, Vol. 95, Supplement 1, March/April, 2004, http://www.cpha.ca/english/cjph/inmates/CJPH_95_Suppl_1_e.pdf.

⁴⁵ 23 February, 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

community mental health services to support offenders on conditional release, has not yet reached communities.⁴⁶

While the stated policy objective of the Commissioner's Directive on Health Services is "to ensure that inmates have access to essential medical, dental and mental health services in keeping with generally accepted community practices," in practice, mental health care at the reception centres, treatment centres and community health services is generally not available.⁴⁷

In practice, mental health care at the reception centres, treatment centres and community health services is generally not available.

13.2.2.1 Reception Centres

The Directive's requirements for standards of care at a reception centre specify that every offender is to receive, within 2 working days of arrival, a nursing assessment that includes a review of acute mental as well as physical health. The main purpose of the initial mental health assessment, however, is to ascertain the level of security risk posed by the offender rather than to determine the full extent of any mental health concerns. Standard suicide risk assessment is also done on entry. If potentially suicidal, the individual can be put under observation for a period of time, and be reassessed accordingly. A comprehensive health status nursing assessment is to occur within 14 days.

The main purpose of the initial mental health assessment, however, is to ascertain the level of security risk posed by the offender rather than to determine the full extent of any mental health concerns.

After admission, offenders reside in the reception centre for the first three months where they receive regular medical care. If the individual requires medication for an identified mental health problem, the nurse can refer them to the institutional physician for further review. If behavioural problems occur, further assessment by a psychologist might be required. Psychiatrists can also meet with offenders in the reception centre.

13.2.2.2 Treatment Centres

If significant mental health problems develop during the time in reception, or if there is a pre-existing diagnosis on entry, offenders may be admitted to one of the five existing regional treatment centres. These centres also deliver programs to sex and violent offenders.

Care in the treatment centre is provided on a 24-hour basis. The individual is stabilized, medication is analysed, and a further assessment is done to determine if transfer to a regular institution is possible. Prior to transfer, the health service file is reviewed to identify all health problems to ensure continuity of care and fitness for program placement at the receiving institution.

⁴⁶ Office of the Correctional Investigator, *Press Release*, "Reports Highlights Dramatic Increase in Numbers of Inmates Mentally Ill — Implementation of National Strategy Urged to address Crisis," 4 November 2005, http://www.oci-bec.gc.ca/release-20051104_e.asp.

⁴⁷ Correctional Service Canada, Commissioner's Directive, "Health Services," Number 800, 2004, http://www.csc-ccc.gc.ca/text/plcy/cdshtm/800-cde_e.shtml.

While continuity of care is the goal of the assessment, few federal offenders receive the treatment they require because of the lack of specific mental health services at the necessary levels.

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13.2.2.3 Regular Institutions

Once an offender is stabilized and assigned to a regular institution, whether a maximum, medium, or minimum security institution, health care personnel oversee each individual. There is no dedicated funding or specialized service for mental health, however.

13.2.2.4 Community Health Services

Offenders on full parole, statutory release and day parole residing in a Community Residential Facility, receive essential health services paid by the applicable provincial health care plan. Pre-release arrangements include application for provincial health care coverage.

Those who reside in a Community Correctional Centre are provided with essential health services by Correctional Service Canada. CSC is also responsible for “other non-insured health care expenses, for offenders residing in a Community Correctional Centre or Community Residential Centre who are unemployed and have no other source of income and who are otherwise ineligible for all other forms of government/community assistance.”⁴⁸ In addition, it is responsible for “non-insured, mental health treatment costs, as stipulated by the National Parole Board or the Correctional Plan, for all conditionally released offenders.”

13.2.3 Assessments of Client Group Needs

13.2.3.1 Facilities

Witnesses seriously doubted the capacity of Correctional Service Canada to meet the needs of offenders with mental health issues through its five existing treatment centres. Howard Sapers noted that:

Witnesses seriously doubted the capacity of Correctional Service Canada to meet the needs of offenders with mental health issues through its five existing treatment centres.

*CSC currently has bed space in their treatment centres to respond to the needs of less than 6% of the inmate population. The Service’s own estimates are that the need is for about 12%.. So, current capacity is less than 50% of identified need.*⁴⁹

Natalie Neault, Director of Investigations, Office of the Correctional Investigator Canada, observed that several treatment centres were not capable of providing services to maximum security offenders. She referred to twelve offenders, all in long term segregation with clear symptoms of mental illness, who were repeatedly refused admission at the Shepody Treatment Centre in Dorchester, New Brunswick, because it was not structured for

⁴⁸ *Ibid.*

⁴⁹ 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

maximum security. In this situation, even when the inmates do receive a visit from a psychologist, the purpose of the visit is not the treatment of mental illness but assessment of the likelihood of suicide:

The facilities and services available to meet the needs of offenders for mental health care should be comparable to the same standards for mental health care as for those provided to the general population.

Moving them out to another region away from their community-which is often all the support they have, and that in itself is very often very limited- is not consistent with the whole purpose of being able to reintegrate these individuals. They remain in segregation units, seeing a psychologist once a month to make sure that they are not suicidal.⁵⁰

Robert Miller, Chief of Psychiatry at the Vancouver Island Health Authority argued that the facilities and services available to meet the needs of offenders for mental health care should be comparable to the same standards for mental health care as for those provided to the general population:

... those in need of hospital care should be treated in hospital and not in prison. Further, when in correctional facilities where people are treated, not everybody needs to be in the hospital. Outpatient mental health care too can be given in prison, but that treatment should be equitable and to the same standard as is available in the local community.⁵¹

13.2.3.2 Community Integration

For offenders with an identified mental health diagnosis who are under treatment and need follow-up by a psychiatrist, Correctional Service Canada tries to assure continuity of service after release. This involves finding a psychiatrist, clinic or hospital that will see the offender upon release and engaging community services in the community release plans. Problems can occur if the offender decides not to go to appointments or to the referral clinic; if the services do not accept the referral; or if the services are not available at the time and place of release. When released to residency in a CSC community centre, services are provided until offenders have left the institutional setting entirely.

The failure to integrate or even coordinate services that involve various provincial and federal government agencies leaves some individuals without necessary medication and at risk of relapsing into crime.

The reality is that the community-based services and interventions are limited and because of the prevailing stigma, many difficulties arise in obtaining access to services for offenders living with a mental disorder. Michael Bettman, Acting Director General, Offender Programs and Reintegration, Correctional Service of Canada noted that stigma can be a major barrier to integration:

⁵⁰ 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁵¹ 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Basically, I think our biggest challenge is, to a large extent, that stigma. These offenders are part of our community and people do not really recognize it. They want to encapsulate them, not only in a prison but even when they are in the community, and they say that their mental health care is the government's responsibility, it is not our town's or city's responsibility, and as a result, we are often left alone trying to service the needs of our offenders.⁵²

The failure to integrate or even coordinate services that involve various provincial and federal government agencies leaves some individuals without necessary medication and at risk of relapsing into crime. Bernard Galarneau, Psychologist, Policy Director, Shepody Healing Centre pointed out that:

Mentally disordered offenders who are receiving psychiatric medication, and who are released from prison, typically have two weeks of medication supply. How quickly can they be seen by a physician or a psychiatrist to have their prescription renewed?⁵³

Jocelyn Greene, Executive Director, Stella Burry Community Services, noted that an innovative community support program based on a home support model for female offenders with complex mental problems offered the prospect of significant savings for both the prison system and the health care system:

An evaluation of the program has shown a dramatic reduction in hospital and incarceration rates. [...] the highlight is the decrease in prison days, which was 73%, and the decrease in hospital bed days, which was 39.2%.⁵⁴

13.2.3.3 Human Resources

Ensuring that there are adequate human resources available to provide mental health services is complicated by the multiplicity of tasks trained professionals are asked to undertake. Françoise Bouchard indicated that there are:

Although inmates in segregation are supposed to be seen once a month by a psychologist, Natalie Neault pointed out that this is not possible.

... about 250 psychologists working in the Correctional Service Canada. However, psychologists do not provide only mental health services. They also carry out risk assessment for correctional purposes. In fact, most of the activities of the psychologists within CSC are directed to the risk assessment part of the correctional agenda.⁵⁵

⁵² 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

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

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

⁵⁵ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Bernard Galarneau, an institutional psychologist at Shepody Healing Centre, explained that, the workload was heavy and focussed more on risk assessment than on mental health:

*With a caseload of anywhere from 100 to 200 inmates there is little time for genuine psychotherapy. You mostly work as a firefighter. You extinguish fires, crises as they arise, and you do a lot of risk assessments.*⁵⁶

Although inmates in segregation are supposed to be seen once a month by a psychologist, Natalie Neault pointed out that this is not possible:

*... there is a waiting list as long as my arm in terms of offenders who want psychological services, and there are very limited resources. There are two psychologists for a population of nearly 300 inmates.*⁵⁷

Christine Davis, President, Canadian Federation of Mental Health Nurses, argued for more training and an expanded role for nurses:

*With proper training, nurses within the prison environment could play a more active role in the area of mental health assessments, evidence-based practice and long-term care of the inmate with mental health issues. Too often, people are incarcerated because of the lack of forensic beds. If nurses providing physical care were supported to perform mental health assessments and treatments, there would be less pressure on forensic institutions and more chance that persons within the justice system affected by mental illness could be directed toward care sooner.*⁵⁸

Witnesses such as Kim Pate, Executive Director, Canadian Association of Elizabeth Fry Societies, recognized that it is not feasible to train all staff in how to perform mental health assessments, but she stressed that it is extremely important to identify offenders with mental health problems and to get them the mental health care they need quickly. She noted that individuals can improve within a short time when they are “seen through the lens of the mental health issues/psychiatric label, not the lens of criminality.”⁵⁹ For Howard Sapers, staff must be trained to distinguish “whether you are dealing with a mental health crisis or a security crisis when you see an inmate who is acting out.”⁶⁰

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

⁵⁷ 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁵⁸ 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁵⁹ 16 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/06eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁶⁰ 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

13.2.3.4 Specific Offender Groups — Segregated, Female, Aboriginal

Segregated offenders are more likely to be recipients of inappropriate assessment; it is less likely that their mental health needs will be fully recognized. Howard Sapers noted that offenders who are locked up in segregation for up to 23 hours a day in maximum security institutions are often intellectually challenged or “present behavioural problems, learning disabilities and/or symptoms of attention deficit hyperactivity disorder, ADHD, or fetal alcohol spectrum disorder, FASD.” He painted a bleak picture of the prospects for these offenders within the correctional system:

Segregated offenders are more likely to be recipients of inappropriate assessment; it is less likely that their mental health needs will be fully recognized.

These offenders are unable to complete regular programs, they are preyed upon by other offenders, they end up in segregation, they have limited coping skills and they are usually classified as maximum security. They do not have the ability or skills required to focus and concentrate in order to complete regular programming. They are very vulnerable and their segregation is usually for a much longer period of time than others in segregation. They are usually referred to see the psychiatrist, who typically finds no evidence of a psychiatric disorder, per se, and identifies these individuals as exhibiting a behavioural problem. These offenders therefore do not meet the criteria that would allow them to benefit from services provided in treatment centres, so they stay in the general institutions. They have limited coping skills, which may cause them to withdraw, self-injure, set fires, attempt or commit suicide, and in some extreme situations assault others or guards.⁶¹

Several witnesses called for staff training on how to provide appropriate interventions for offenders with disorders that might result in segregation and also for appropriate training for staff working with those who are segregated. Natalie Neault explained the need to ensure that those with learning disabilities are properly assessed on reception as they “have difficulty following orders from the officers and thus end up being charged, in segregation, and receiving a disciplinary sanction.”⁶² Kim Pate described her experience with segregated female offenders:

Natalie Neault explained the need to ensure that those with learning disabilities are properly assessed on reception as they “have difficulty following orders from the officers and thus end up being charged, in segregation, and receiving a disciplinary sanction”.

Women were particularly affected by deinstitutionalization as well as by cuts in social programs, suggesting that for some women prison is seen as an alternative care system.

... I have been on my knees in front of a segregation cell, talking to someone through a meal slot, trying to convince her to stop smashing her head on the

⁶¹ 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁶² 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

*wall, and had staff say that they are told to count to 20, because that is when it is no longer just an attention-getting behaviour, it may be life-threatening. That is not because those staff are ill-intentioned, but they have been trained to believe that up to a certain point, it may just be a manipulative behaviour.*⁶³

Although women constitute a small group, an estimated 400 in the federal offender population, they have particular mental health concerns. Howard Sapers pointed to a study comparing admissions to federal institutions in 1967 and 2004 that indicated a 65% increase in the number of female offenders with mental disorders, a figure that increases if substance abuse is included. He also noted:

*Correctional Service of Canada recognizes that women in federal institutions have a higher rate of self-mutilation and attempted suicide than do their male counterparts. The CSC research branch found that more than two-thirds of women in maximum security had previously attempted suicide, compared with 21% of maximum security males. So it is about three times.*⁶⁴

Kim Pate argued that women were particularly affected by deinstitutionalization as well as by cuts in social programs, suggesting that for some women prison is seen as an alternative care system:

*With the cuts to national standards for health care, social services and education occasioned by the elimination of the Canada Assistance Plan [...], we also saw increased numbers of people who fell through all of those service cracks, and ended up in the criminal justice system. That is because it is really the only system that cannot close its doors and say, "No, we are full, our beds are full," and it is not difficult to characterize behaviour that is symptomatic often of mental illness as also criminal.*⁶⁵

Several witnesses also pointed to the over-representation of Aboriginal peoples in the criminal justice system. According to Michael Bettman, specific programs have been designed by Aboriginal people and often delivered by Aboriginal people to Aboriginal offenders. He noted that:

Significant cost saving could be achieved by reaching Aboriginal children in a positive way before they interact negatively with the law.

*... Aboriginal people represent 3% of the population but 17% of our offender population. In the Prairie region, that number is approaching 65%.*⁶⁶

⁶³ 16 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/06eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁶⁴ 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁶⁵ 16 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/06eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁶⁶ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Darrell Downton, Co-Chair, Mental Health and Addictions Advisory Committee, Five Hills Regional Health Authority, emphasized the need for prevention. He insisted that significant cost saving could be achieved by reaching Aboriginal children in a positive way before they interact negatively with the law:

A lot of times there may be programs that are in place once they are in the justice system but it is much more important to have that intervention process and plan in place to reach these children before they ever get into the justice system. It saves \$50,000 a year plus many other things, in terms of benefits to society.⁶⁷

13.2.3.5 Addictions

According to Michael Bettman, close to 80% of federal offenders had a substance abuse problem that is connected to reoffending. He emphasized that Canada's substance abuse program is internationally accredited and is emulated by various European countries:

We have a national substance abuse program in our maximum, medium and minimum security institutions, with maintenance afterwards. These are programs focused on harm reduction strategies for the offender to reduce and prevent further substance abuse. These programs are followed up by maintenance throughout the offender's sentence, both in the institution and in the community, once they are released.⁶⁸

Howard Sapers recommended that CSC implement various measures to improve the situation for offenders with substance abuse problems:

... a prison-based needle exchange program to deal with the public health risks associated with the growing infection rate of hepatitis-C and HIV. There are several jurisdictions in Europe that have prison-based needle exchange programs. They work, in the sense that infection rates are down and the release of healthy inmates has increased. There have been no reported increases either in the incidence of drug abuse within prisons or the use of syringes in assaults...⁽⁶⁹⁾

Michael Flaxman, a volunteer with the From the Heart Committee in Toronto, called for those offenders with histories of non-violent drug related crimes to be separated and provided with different programs that focus primarily on addictions:

The lack of continuity between institutional and community based programs and services leads to various problems for offenders who are released.

⁶⁷ 2 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/17eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁶⁸ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁶⁹ 7 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/19eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

... why not have a low-medium security facility that deals with non-violent drug-related crimes that delivers programs along a specific continuum that are specific to the needs of addicts. These individuals tend to be serving shorter sentences than others, and with accelerated parole review at which they are eligible for day parole at the one-sixth point of their sentence, their focus can be solely on their addictions.⁷⁰

The lack of continuity between institutional and community based programs and services leads to various problems for offenders who are released. According to Ron Fitzpatrick, Executive Director, Turnings, when an offender who has been on methadone is released, an equivalent program to that available within the correctional milieu must be immediately available in the community, yet frequently it is not:

He needs to be in a methadone program because he has been on it these five years. If he does not get in it right away because of waiting lists, he can be back on the street using street drugs because that is his only alternative, and he ends up back in jail. If he gets sentenced to our provincial prison for stealing for drugs, he goes to prison and he may or may not get into a methadone maintenance program.⁷¹

13.2.4 Committee Commentary

The Committee has one primary goal for federal offenders — and by extension, for provincial correctional populations — it wants the standard of care for mental health within correctional institutions (and in post-release settings) raised to be equivalent to that available to “non-offender members” of the general community. Not meeting this goal is to condemn far too many offenders to a life of going through a revolving door, repeatedly in and out of prison. If the goal of incarceration is rehabilitation as well as public safety, this goal must be met. If it is not, the conclusion must be that Correctional Service Canada places a much higher priority on retention than on rehabilitation.

The Committee has one primary goal for federal offenders — and by extension, for provincial correctional populations — it wants the standard of care for mental health within correctional institutions (and in post-release settings) raised to be equivalent to that available to “non-offender members” of the general community. If the goal of incarceration is rehabilitation as well as public safety, this goal must be met.

The needs of incarcerated people suffering from mental illnesses and addiction can only be met through a significant change in the programs, funding and attitude of CSC.

The Committee urges Correctional Service Canada to give a higher priority to mental health and addiction needs — to devote as much attention to these needs as it does to risk assessment and security issues, to ensure that treatment and rehabilitation are smoothly coordinated.

⁷⁰ 15 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/05evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

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

The Committee understands that the needs of incarcerated people suffering from mental illnesses and addiction can only be met through a significant change in the programs, funding and attitude of CSC. At the outset it requires a thorough mental health screening when an offender accesses a federal penitentiary. It requires funding to provide the programs and services to meet the mental health needs of the prison population. It requires that CSC ‘walk the talk’ with respect to the priority to be given to rehabilitation versus retention for public safety. The Committee also recognizes that consistent data collection and careful analysis as well as an expanded research capacity related to mental health will be necessary. In summary, the Committee urges Correctional Service Canada to give a higher priority to mental health and addiction needs – to devote as much attention to these needs as it does to risk assessment and security issues, to ensure that treatment and rehabilitation are smoothly coordinated.

To achieve equivalent standards of care for mental health for federal offenders within institutions and in post-release settings, the Committee recommends:

72	<p>That Correctional Service Canada (CSC) develop and implement standard of care guidelines for mental health to be applied within institutions and in post-release settings that are equivalent to those applied in settings accessed by the general population.</p> <p>That CSC guidelines be based on the collection of statistical information about federal offenders and their mental health disorders and addictions, including prevalence rates for mental health disorders, type of treatment utilized (psychotherapy, medication, etc.), rate of hospitalization, etc.</p> <p>That CSC performance with respect to implementing the guidelines be reviewed annually by an independent external body with mental health expertise such as the Canadian Mental Health Commission (see Chapter 16).</p> <p>That data used for the guidelines be compiled and made available to the public and that the raw data be made available to researchers for independent analysis.</p> <p>That the performance assessment be reported to Parliament annually starting in 2008.</p>
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With respect to those offenders in need of mental health care and treatment while in regular correctional facilities, the Committee believes all staff should be trained to distinguish between a mental health crisis and a security crisis. Offenders must receive needed psychotherapy and other appropriate therapies from professionals who are trained specifically to deal with mental health issues.

The Committee urges that a full mental health assessment of offenders by trained professionals occur at the time of their arrival at a reception centre, and that it be completed within a shorter time frame than is currently the case. It supports expanded harm reduction efforts along with better treatment services for addicted offenders. Going beyond the existing methadone program, the Committee is in favour of a full assessment of the advantages and disadvantages of establishing needle exchange services with federal institutions.

The Committee recommends:

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

The Committee recommends:

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

... about half of the people who do have issues are not coming forward to seek help, so we are still working on that. Is there a stigma? There is less than there used to be, but I am concerned that we are creating a two-tiered category of mental illness. It is perhaps acceptable to have an operational stress injury or PTSD [posttraumatic stress disorder]; it is not acceptable to have ordinary depression in the military. —Brigadier-General Hilary F. Jaeger, Surgeon General, National Defence⁷²

13.3.1 Federal Responsibility

Under subsection 91(7) of the *Constitution Act, 1867*, sole responsibility for all military matters, including military health care, is assigned to the federal government. The 1984 *Canada Health Act* specifically excludes “a member of the Canadian Forces” from the definition of “insured persons.” They are also excluded from insurance coverage under provincial health care plans and from coverage under the Public Service Health Care Plan.

Through the *National Defence Act*, the Minister of National Defence is given the authority for the management and direction of the Canadian Forces.⁷³ As explained by Brigadier-General Hilary F. Jaeger, Surgeon General, National Defence:

In comparing the Canadian Forces with the civilian population, she reported the “prevalence of depression in the year preceding the survey was 80% higher than that found in the general population.”

... the federal government has responsibility for, and authority over, all aspects of health care for regular force members from the time they join until the time they retire, and entitled reservists, including mental health care.⁷⁴

According to the departmental Performance Report for the period ending 31 March 2005, the size of the regular force numbered 61,715 in 2004-2005.⁷⁵ The actual strength of the primary reserve force for 2004-2005 was 25,633 personnel.⁷⁶

While posttraumatic stress disorder is often the primary focus for mental illness in the Canadian Forces, it is not among the three most prevalent disorders.

To determine the burden of mental illness among members of the regular and reserve forces, National Defence and Statistics Canada developed the 2002 Canadian Forces supplement to the Canadian Community Health Survey. This survey permitted comparisons between the

⁷² 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁷³ *National Defence Act*, R.S. 1985, c. N-5, <http://laws.justice.gc.ca/en/N-5/>.

⁷⁴ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁷⁵ National Defence, *Performance Report For the Period ending March 31, 2005*, p. 115, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/ND-DN/ND-DN45_e.pdf.

⁷⁶ *Ibid.*, p. 88; The Primary Reserve is made up of the Naval Reserve, the Army Reserve, the Air Reserve, the Communication Reserve, the Health Services Reserve, the Legal Reserve, and the National Defence Headquarters Primary Reserve List.

Canadian public at large and members of the Canadian Forces with respect to the prevalence of certain mental illnesses, perceptions of well being and the use of services.⁷⁷

Brigadier-General Jaeger noted that members of the regular force reported an annual incidence of mental health problems of about 15% compared to 13% in the reserves and a lifetime prevalence of mental illness of between 30 and 35%.⁷⁸ In comparing the Canadian Forces with the civilian population, she reported the “prevalence of depression in the year preceding the survey was 80% higher than that found in the general population.”⁷⁹

Furthermore, Brigadier-General Jaeger told the Committee that, while posttraumatic stress disorder is often the primary focus for mental illness in the Canadian Forces, it is not among the three most prevalent disorders:

Depression is our leading cause of suffering at 7.6% in the year preceding the survey. Alcohol abuse or dependency hit 4%, and social phobia 3.6%. PTSD was 2.8% and panic disorder 2.2% — all in the regular force, which, generally speaking, has a somewhat worse incidence of mental illness than the reserve forces.⁸⁰

13.3.2 Federal Programs and Services

Brigadier-General Jaeger reported that the Canadian Forces has engaged in a systematic renewal of its approach to mental health care, and has begun to implement a model of mental health care delivery that addresses multiple factors:

We believe in a very holistic look at mental health. We believe that it is that component of health that pertains to cognitive, emotional, organizational and spiritual matters, and is much more than the mere absence of psychiatric illness; so that sets us a fairly high standard.⁸¹

In November, 2005, the Office of the Surgeon General released a “backgrounder” providing an update on Canadian Forces Mental Health Programs.⁸² The information covered health services delivery, health protection, casualty support, family support, the mental health

⁷⁷ National Defence, *Statistics Canada CF Mental Health Survey*, “A milestone,” http://www.forces.gc.ca/health/information/op_health/stats_can/engraph/MH_Survey_e.asp.

⁷⁸ Correspondence from Brigadier-General Hilary F. Jaeger, Surgeon General, National Defence to Senator Michael Kirby, Chair, Standing Senate Committee on Social Affairs, Science and Technology, The Senate, 2 February, 2006 pointed out that, as the survey did not measure all types of mental illness, the true lifetime prevalence is likely higher.

⁷⁹ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁸⁰ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁸¹ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁸² National Defence, *News Room Backgrounder*, “Canadian Forces Mental Health Programs — Update,” BG 05.037, 10 November 2005, http://www.dnd.ca/site/newsroom/view_news_e.asp?id=1804.

component of Rx2000 (acronym for the Canadian Forces Health Services Reform restructuring project) and partnerships with Veterans Affairs Canada.

13.3.2.1 General Mental Health Services

The Department of National Defence provides Canadian Forces members with non-emergency, outpatient care through base clinics, health care centres and support units at military installations across Canada. These units treat non-life threatening illnesses, perform minor surgical procedures, counsel on minor mental health issues, and provide medication as needed.⁸³

Most specialized mental health services are purchased from the provinces.

If the need for services occurs after operational hours, involves a serious medical emergency, or is in a remote geographical location, CF members receive care at civilian hospitals or other health care facilities. Although larger military clinics can provide specialty services for mental health, most specialized mental health services are purchased from the provinces.

The Canadian Forces Health Services Reform (*Rx2000*) is a comprehensive medical restructuring project that includes a mental health component. Recent funding commitments totalling \$98 million over six years are expected to enhance CF mental health care delivery through several initiatives:

- Increasing the number of mental health providers available to CF members across the country;
- Developing standardized approaches to the assessment and treatment of key conditions and ensuring all staff is equally comfortable with the preferred therapeutic approaches;
- Refining deployment-related psychosocial screenings to allow for earlier intervention;
- Improving educational outreach services;
- Conducting research to improve practices and to measure outcomes.

13.3.2.2 Operational Trauma Stress Support

Canadian Forces personnel face unique stressors when deployed on combat, conflict resolution, and peacekeeping missions. The duties that are performed as part of the military life can result in the very traumatic experience of multiple casualties, armed attacks, hostage-taking, massacres, deaths of co-workers and civilians, etc.

In 1999, the department opened five Operational Trauma and Stress Support Centres at bases in Halifax, Valcartier, Ottawa, Edmonton, and Esquimault. They focus on psychological, emotional, spiritual and social problems that arise from military operations.

⁸³ National Defence, *Canada's Military Health System*, "In-Garrison Health Services," http://www.forces.gc.ca/health/about_us/engraph/in_garrison_e.asp.

In 2002, DND and Veterans Affairs Canada jointly launched the Operational Stress Injury Social Support (OSISS) project, a Canada-wide peer-support network to assist members and former members suffering from operational stress injuries (OSI).

Operational stress injury (OSI) is defined as any persistent psychological difficulty resulting from operational duties performed by a Canadian Forces member and includes posttraumatic stress disorder (PTSD).⁸⁴ In 2003, preliminary findings from an evaluation of enhanced post-deployment health screening for CF members on operation in Afghanistan/SW Asia revealed “disturbing levels of impaired physical and mental well-being.”⁸⁵ On the positive side, many individuals with these problems were identified and referred for care.

13.2.2.3 *Stress and Addictions*

When duties take them away from their families, both the process of separation and of eventual reunion create particular emotional demands and stresses for CF members. In 2000, the Directorate of Medical Policy at National Defence prepared a series of pamphlets on stress, including deployment stress and reunion stress as well as critical incident stress.⁸⁶

Departmental policies on alcohol and drugs provide guidance on effective interventions.⁸⁷ Supervisors are encouraged to recognize early warning signs of alcohol, drug and gambling addiction and to intervene early to prevent later health and safety problems. Initial steps can include educational sessions and the involvement of medical personnel, while addiction counselling and treatment programs can be prescribed by an attending physician.

The department also offers programs to promote mental health and prevent negative behaviours linked to stress, such as addictions, family violence and suicide. The interdisciplinary approach of these programs involves psychiatrists, clinical psychologists, mental health nurses, social workers, addiction counsellors and chaplains, all of whom share responsibility with primary care providers.

⁸⁴ Operational Stress Injury Social Support, *Information for Canadian Military, Former and Serving*, “What are Operational Stress Injuries?”
http://www.osiss.ca/sitePage.txp?ud_siteSectionId=14347&tx_target=main1131814980596.

⁸⁵ Mark Zamorski, *Evaluation of an Enhanced Post-Deployment Health Screening Program for Canadian Forces Members Deployed on Operation OPOLLO (Afghanistan/SW Asia): Preliminary Findings and Action Plan*, June 2003,
http://www.forces.ca/health/information/op_health/op_apollo/engraph/op_apollo_toc_e.asp.

⁸⁶ National Defence, Directorate of Medical Policy, series of booklets titled *Preparing for Critical Incident Stress, Preparing for Deployment Stress, Preparing for Reunion Stress*, 2000,
http://www.forces.gc.ca/health/information/engraph/health_promotion_home_e.asp?Lev1=2&Lev2=5.

⁸⁷ National Defence, *Aide Memoire for the Supervisor's Role in Dealing with Alcohol Misuse*, DCOS Force Health Protection, 2004,
http://www.forces.gc.ca/Health/Services/health_promotion/PDF/Aide%20Memoire%20for%20the%20Supervisor%27s%20Role%20in%20Dealing%20with%20Alcohol%20Misuse.pdf.

13.2.2.4 Medical Releases

Brigadier-General Jaeger estimated that about 42% of all medically-related time off work among CF personnel was for mental health issues, and that about 23% of CF members who are released for medical reasons have mental illness as their primary diagnosis.⁸⁸ She noted that the department is able to adapt work situations to a larger degree than most employers and that this helps to reduce the need to release members from military service:

About 42% of all medically-related time off work among CF personnel was for mental health issues.

*We can direct part-time work, we can direct work of less stress, and we can direct work of less physical stress.*⁸⁹

Nonetheless, Colonel D. R. Boddam, Canadian Forces practice leader for psychiatry and mental health, National Defence, told the Committee that, while a majority of individuals diagnosed with mental illness return to work after treatment, about 300 people yearly are released for reasons related to mental illness. He noted that National Defence has recently established a project to work with Veterans Affairs Canada:

*For those people who have sustained a mental injury as a result of their employment, we wish to work together to be able to provide that continuity in a seamless way, from where they start to get care to when they become civilians.*⁹⁰

Brigadier-General Jaeger emphasized that medical releases from the military and employment restrictions are a serious issue for the department as well as for the affected members:

While a majority of individuals diagnosed with mental illness return to work after treatment, about 300 people yearly are released for reasons related to mental illness.

*About 2300 of our members every year undergo a review of their suitability to continue serving in the Canadian Forces. About 23% of these cases every year are due to mental illness and that perhaps is not surprising. They are disproportionately likely to end up being released from the Canadian Forces.*⁹¹

⁸⁸ Correspondence from Brigadier-General Hilary F. Jaeger, Surgeon General, National Defence to Senator Michael Kirby, Chair, Standing Senate Committee on Social Affairs, Science and Technology, The Senate, 2 February, 2006.

⁸⁹ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08eve.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁹⁰ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08eve.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁹¹ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08eve.htm?Language=E&Parl=38&Ses=1&comm_id=47.

13.3.3 Assessments of Client Group Needs

13.3.3.1 General Mental Health Care

Brigadier-General Jaeger acknowledged the challenge of providing team-based mental health care to meet the needs of CF members. She pointed out that the department will have to double its personnel and that finding trained people to fill these positions will be difficult, since the department will “have to recruit professionals from the civilian sector, where we know there is already an overall shortage of care providers.”⁹²

Colonel Boddam noted that the dependence upon the civilian health care system to treat more severely ill members is also a concern for CF members with serious mental illness:

*Psychiatric beds exist at a premium. We do not run our own, and we cannot always readily access such beds. This is a particular concern for us as the highly mobile nature of military careers means that support systems such as extended family and friends of long standing are less likely to be able to provide help when a member is suffering.*⁹³

A number of joint efforts of National Defence and Veterans Affairs Canada are intended for still-serving Canadian Forces members as well as those in transition to civilian life. Brigadier-General Jaegar expressed optimism about the current partnership and the goal of consistency in mental health services:

The dependence upon the civilian health care system to treat more severely ill members is also a concern for CF members with serious mental illness.

*The vision is to have VAC mental health resources available to members of the CF where this makes sense, and CF mental health resources available to VAC where this makes sense. It is desired by us that blended staffing eventually take place.*⁹⁴

13.3.3.2 Mental Health Outcomes

In response to concerns that revealing a mental illness might lead to the termination of a person’s military career, rather than having them return to work after treatment, Brigadier General Jaeger said:

The access to, and adequacy of, pensions for individuals who are medically released was also raised as an issue.

The vast majority of people who present with a mental illness receive appropriate treatment and go back to work. They are invisible to everyone else. We would like to have a spokesperson that is willing to stand up and say, “I did that.” We have General Dallaire, who has been an eloquent spokesperson

⁹² 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08eve.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁹³ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08eve.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁹⁴ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08eve.htm?Language=E&Parl=38&Ses=1&comm_id=47.

*for posttraumatic stress disorder and operational stress injury, who did end up having to take his retirement from the Canadian Forces. However, we would like to have a public example who is willing to be a spokesperson from the other side. With confidentiality concerns, we cannot force people to do that. We can only ask for volunteers.*⁹⁵

The access to, and adequacy of, pensions for individuals who are medically released was also raised as an issue. Brigadier General Jaeger voiced particular concern about stringent eligibility criteria for the Service Income Security Insurance Plan (SISIP).⁹⁶ This group insurance plan provides long term disability insurance to Canadian Forces members who become injured or disabled and are medically released:

On the question of pensionability, if you are medically released from the Canadian Forces at any point past 10 years of service, you are entitled to an immediate annuity based on the number of years of service, 2% per year of service. If you are released after 16 years of service, it is a 32% pension indexed to the rate of inflation. You are entitled to the Service Income Security Insurance Plan, SISIP, which augments that to 75% of your salary but only if you meet their criterion, which is all-occupation disability. It is a stringent disability to meet.

*If you make the case with Veterans Affairs that your disability is attributable to military service or has been exacerbated by military service, you will receive a favourable response from their administrators and would be eligible for whatever percent disability you end up being awarded.*⁹⁷

13.3.3.3 Mental Health Redress

In recent years, two avenues have opened for Canadian Forces members with grievances related to mental health and other issues emanating from their work. In 1998, the Minister established an Ombudsman position within the department to investigate complaints and to serve as a neutral third party on matters related to members and employees of National Defence and the Canadian Forces. In 2000, the Canadian Forces Grievance Board was created as a separate, independent civilian administrative tribunal with the power to hear grievances related to various aspects of military life, including entitlement to medical care.

As recently as 2004, the Ombudsman conducted a follow-up investigation on operational stress.⁹⁸ He praised the high quality of care provided at Operational Stress Injury Support Clinics; the increased level of funding committed to the treatment of Operational Stress

⁹⁵ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁹⁶ Canadian Defence Academy, *Moving On — A Handbook for Canadian Forces Members Preparing for Release*, “Chapter 8 — Disability Benefits and Pension,” 2002, http://www.cda.forces.gc.ca/er/engraph/mss/handbook/pdf/Eng_Chapter_8.pdf.

⁹⁷ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

⁹⁸ National Defence Ombudsman Office, *Annual Report 2004-2005*, June 2005, http://www.ombudsman.forces.gc.ca/reports/annual/2004-2005_e.asp#Battle.

Injuries; the successes of the Operational Stress Injury Social Support group that provided peer support to over 1,000 CF members. The Ombudsman's report called for further work, however, including:

*... training and education to change attitudes about operational stress injuries; communications between the operational chain of command and those who provide treatment to CF members suffering from Operational Stress Injuries; and coordination of OSI training, education and initiatives across the CF.*⁹⁹

The Ombudsman Office of National Defence received multiple complaints about release (218), medical (97) and posttraumatic stress disorder (35) in 2004-2005. The Canadian Forces Grievance Board does not provide clear identification of cases related to mental health issues.¹⁰⁰

13.3.4 Committee Commentary

The Committee is pleased that the Department of National Defence offers such a wide array of services to Canadian Forces members who may experience mental health problems. The provision of services for family support as well as medical treatment and casualty support is commendable. The Committee is especially supportive of increased efforts to reduce the stress incurred for CF members and their families due to factors such as separation for operational reasons and frequent relocations.

The Committee is pleased that the Department of National Defence offers such a wide array of services to Canadian Forces members who may experience mental health problems.

The provision of services for family support as well as medical treatment and casualty support is commendable.

The Committee is aware that many of these mental health programs and services are relatively new and are dispersed across many military establishments. These initiatives should be adequately evaluated and the results reported to Parliament.

The Committee recommends:

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| 75 | <p>That National Defence develop an annual inventory of its programs and services for mental health;</p> <p>That the inventory include a clear description of each program or service with number of clients served, the amount of funding allocated and spent, and any evaluation of outcomes achieved;</p> <p>That the inventory be reported to Parliament annually starting in 2008.</p> |
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⁹⁹ *Ibid.*, section titled "Following up on the CF's Treatment of Members Suffering from OSIs."

¹⁰⁰ Canadian Forces Grievance Board, see case summaries section in index, PTSD did not appear in a search; one drug addiction case was found; <http://www.cfgb-cgfc.gc.ca/index-e.php>

The Committee understands that many serving members of the Canadian Forces and Canadian Forces veterans as well are reluctant to talk about their traumatic experiences. The Committee believes that the department has a responsibility to provide multiple and frequent opportunities for military members still-serving to address the implications of operational stress injuries. Although social support for Canadian Forces members and their families has improved and their access to necessary programs and services has increased, the Committee believes that more work can be done by the department to enhance the peer support network and, in the longer term, to implement cultural change to ensure early identification and follow-up services to address the needs of both members and their families with operational stress injuries. This includes, not only a focus on posttraumatic stress disorder, but on anxiety disorders and depression as well as other symptoms of stress such as alcohol or drug abuse and family dysfunction.

The Committee believes that more work can be done by the department to enhance the peer support network and, in the longer term, to implement cultural change to ensure early identification and follow-up services to address the needs of both members and their families with operational stress injuries.

The Committee recommends:

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| 76 | <p>That National Defence require that all medical personnel receive mandatory training with respect to operational stress injury and that this training include:</p> <ul style="list-style-type: none"> • proper recording of military and trauma histories; • methods to recognize/detect symptoms of operational stress injury; • understanding of multiple treatment modalities; and • appropriate long-term follow-up processes; <p>That National Defence make the information available to National Defence and civilian medical personnel through publications, seminars, or other public forums;</p> <p>That National Defence explore measures to encourage more widespread use of peer counselling and increased engagement of family and community.</p> |
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The Committee is also concerned about the Reservists who work with National Defence but have a different relationship to the department than do regular Canadian Forces members. When they return from mobilization missions and exercises, they may not have access to the support offered on military bases. The Committee believes that the department has a responsibility to ensure that follow-up services are readily available to Reservists as well. Sufficient time must be allowed for an orderly transition from regular to reserve units, ensuring that Reservists are given adequate medical assessments, with proper evaluation of the potential for operational stress injury. For the department, this may require that the employment commitment for Reservists be extended while they are being properly screened.

The Committee recommends:

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

13.4 VETERANS

... good mental health is important for re-establishment, good re-establishment programming is important for mental health. — Brian Ferguson, Assistant Deputy Minister, Veteran Services Branch, Veterans Affairs Canada¹⁰¹

13.4.1 Federal Responsibility

Unlike serving members of the Canadian Forces, veterans are considered to be “insured persons” under the *Canada Health Act* with respect to mental (and other) health services. For most veterans, Veterans Affairs Canada (VAC) does not provide health insurance to cover services above and beyond those offered by the provinces or territories, although income-qualified veterans may get some additional assistance. Veterans with disability pensions do receive financial coverage for treatment of their pensioned condition.

For most veterans, Veterans Affairs Canada (VAC) does not provide health insurance to cover services above and beyond those offered by the provinces or territories, although income-qualified veterans may get some additional assistance.

The principal legislative authority for veterans and their health care is found in the *Department of Veterans Affairs Act* and the *Pension Act* and, since 2005, in the *Canadian Forces Members and Veterans Re-establishment and Compensations Act*.¹⁰² Under the *Department of Veterans Affairs Act*, the *Veteran’s Health Care Regulations* define health as a state of physical, mental and social well-being. This Act outlines eligibility for multiple benefits including medical care, home adaptations, travel costs for examinations or treatment and other community health care services.¹⁰³

The *Pension Act* defines disability as “the loss or lessening of the power to will and to do any normal mental or physical act.” The *Canadian Forces Members and Veterans Re-establishment and Compensation Act* authorizes the Minister to provide job placement assistance, rehabilitation

¹⁰¹ 23 February, 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁰² *Department of Veterans Affairs Act*, R.S. 1985, c. V-1, <http://laws.justice.gc.ca/en/V-1/> and *Pensions Act*, R.S. 1985, c. P-6 <http://laws.justice.gc.ca/en/P-6/>; *Canadian Forces Members and Veterans Re-establishment and Compensation Act*, http://www.parl.gc.ca/PDF/38/1/parlbus/chambus/house/bills/government/C-45_4.PDF.

¹⁰³ *Veterans Health Care Regulations*, <http://laws.justice.gc.ca/en/V-1/SOR-90-594/>.

services, vocational assistance and financial benefits, disability awards, and health benefits for Canadian Forces members and veterans.

Brian Ferguson, Assistant Deputy Minister, Veteran Services Branch, Veterans Affairs Canada, described the departmental process that is followed for mental health services:

Under the Veterans Health Care Regulations, if a need for health care is related to a pension condition, Veterans Affairs Canada will pay for those treatment benefits directly. For eligible veterans, we will pay for non-pension conditions if the service is not covered under provincial health care plans.

With the exception of those services provided at our own Ste. Anne's Hospital, all health services provided to our clients are delivered either by provincial jurisdictions, non-governmental organizations or private registered providers. Through our network of regional and district offices, we have an ongoing relationship with provincial governments.¹⁰⁴

As of March 2005, VAC was providing benefits and services to approximately 219,000 clients.¹⁰⁵ These include military personnel and others:

- members of the Canadian Forces and Merchant Navy veterans who served in the First World War, the Second World War or the Korean War;
- certain civilians who are entitled to benefits because of their wartime service;
- former members of the Canadian Forces (including those who served in Special Duty Areas) and the Royal Canadian Mounted Police;
- survivors and dependents of military and civilian personnel.

Speaking specifically about disability pensions and health care, Brian Ferguson reported the number of clients served by the department to be slightly fewer, approximately 209,000 people. He also pointed out the significant increase in Canadian Forces clients among those served by VAC:

... 18% of [our clients] are Canadian Forces members and veterans. Their numbers have increased 58% in the last three years and we anticipate having more than 58,000 Canadian Forces clients by the year 2013.¹⁰⁶

Mr. Ferguson explained that a survey of Canadian Forces members and ex-Canadian Forces personnel showed that 15% of responders reported symptoms of posttraumatic stress

¹⁰⁴ 23 February, 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁰⁵ Veterans Affairs Canada, *2004-2005 Performance Report*, p. 10, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/VAC-ACC/VAC-ACCd45_e.pdf.

¹⁰⁶ 23 February, 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

disorder but had never applied for a pension. Despite the potential under-application, he reported that:

We have more than 8,000 clients pensioned for mental health-related conditions. More than half of these clients suffer from PTSD alone, and the incidence among our younger CF members is increasing each year.

13.4.2 Federal Programs and Services

13.4.2.1 Disability Pension Program

Pension entitlement depends on the nature of the claimant's service. For war, peacekeeping service and other special duty service, the relevant injury or disease must have been incurred during, or be attributable to, the claimant's service. For peacetime military and RCMP service, the claimed injury or disease must have arisen out of, or be directly connected with, the service. This leads to two different types of pension coverage as described by the Veterans Review and Appeal Board:

The disability pension is based on the severity of the disability, as verified by a medical examination, and is assessed in accordance with an established Table of Disabilities. This disability pension program has been the gateway to the health care benefits and other programs offered by Veterans Affairs Canada.

The first, for war, peacekeeping and special duty service, is intended to provide 24 hour a day coverage and consequently is commonly referred to as the insurance principle. The second, for peacetime military and RCMP service, is known as the compensation principle. The coverage is meant to be similar to that provided under workers' compensation programs.¹⁰⁷

Veterans Affairs Canada administers the *Pension Act* and through the Disability Pension Program provides disability pensions to those suffering from disabilities related to peace or wartime military service and to eligible RCMP members. The disability pension is based on the severity of the disability, as verified by a medical examination, and is assessed in accordance with an established Table of Disabilities.¹⁰⁸

This disability pension program has been the gateway to the health care benefits and other programs offered by Veterans Affairs Canada, benefits and programs that were designed to meet the needs of traditional war service veterans rather than the present-day Canadian Forces members and veterans.

The New Veterans Charter — the *Canadian Forces Members and Veterans Re-establishment and Compensations Act* — has changed the process, however. Draft regulations published in December 2005 are more responsive to the needs of Canadian Forces members who are

¹⁰⁷ Veterans Review and Appeal Board, *Annotated Pension Act*, 2005, <http://www.vrab-tacra.gc.ca/Documents/AnnotatedAct-March2005.pdf>.

¹⁰⁸ Veterans Affairs Canada, *2004-2005 Performance Report*, p. 17, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/VAC-ACC/VAC-ACCD45_e.pdf.

released due to disability.¹⁰⁹ The regulations are targeted to fill gaps in programs and services for eligible members released for medical reasons and for members who voluntarily leave the Canadian Forces and then develop later a service-related disability.

The introduction to the draft regulations states:

[T]he New Veterans Charter will bolster the current benefit packages provided by the Service Income Security Insurance Plan (SISIP) and VAC. Most CF members who voluntarily release and later develop a service-related disability could, up to now, only qualify for a VAC pension and related health care. SISIP will continue to provide eligible medically releasing CF members with income replacement and vocational rehabilitation benefits. Under the New Veterans Charter, VAC will meet the needs of the “gap” group and will provide top-up benefits for the SISIP group, such as additional vocational rehabilitation or earnings loss benefits, medical or psychosocial rehabilitation, and Canadian Forces income support.¹¹⁰

13.4.2.2 Health Benefits Program

At present, clients eligible for health care benefits or services are provided with a VAC Health Care Identification card that gives them access to providers across the country. Veterans Affairs Canada delivers a wide range of services and benefits covered under the mandates of the Treatment and Benefits, Long-term Care, and Veterans Independence Programs. These include:

It is expected that the proposed Health Benefits Program “will fill gaps in post-release health coverage by ensuring that medically released CF Veterans have access to group family health insurance.”

- Community-based mental health care (including a comprehensive range of health care benefits not provided provincially) for war and Canadian Forces veterans who meet service and income requirements or who have been awarded disability pensions resulting from military service;
- Institutional mental health care (largely psycho-geriatric, including Alzheimer care) to eligible veterans in the departmental hospital at Ste-Anne-de-Bellevue, Quebec, in contract hospital beds located in provincial health care institutions and in hospitals of choice;
- General mental health care as well as care for posttraumatic stress disorder and operational stress, through services offered jointly with the Department of National Defence.

¹⁰⁹ Government of Canada, *Canada Gazette*, “Canadian Forces Members and Veterans Re-establishment and Compensation Regulations,” Vol. 139, No. 51, 17 December 2005, <http://canadagazette.gc.ca/partI/2005/20051217/html/regle7-e.html>.

¹¹⁰ *Ibid.*, Service Income Security Insurance Plan (SISIP) is described in the previous Canadian Forces section 13.3.3.2.

The *Canadian Forces Members and Veterans Re-establishment and Compensation Act* authorized the Minister to “establish or enter into a contract to acquire a group health insurance program comparable to the Public Service Health Care Plan established by Treasury Board.”¹¹¹ It is expected that the proposed Health Benefits Program “will fill gaps in post-release health coverage by ensuring that medically released CF Veterans (with some exceptions for reservists), CF Veterans with a ‘rehabilitation need’ and certain survivors who are currently ineligible for health coverage have access to group family health insurance.”¹¹²

13.4.2.3 Joint Efforts on Mental Health

Some programs and services resulting from the joint VAC/DND mental health strategy announced in 2002 include:

- VAC assistance line in partnership with DND and Health Canada to provide telephone crisis counselling services for veterans and their families;
- joint DND/Veterans Affairs centre in Ottawa for the care of injured and released members veterans and families with assistance expedited through a 1-800 number;
- cross-Canada case worker system of VAC and DND for early identification of the transition needs of clients, including their needs for disability assistance;
- network of operational stress injury clinics across the country with St. Anne’s Centre taking the clinical lead and others in London, Winnipeg, and Quebec City.¹¹³

The mental health strategy also includes continuing education to keep staff aware of changes to services and programs designed to meet changing client needs and ongoing research in the area of operational stress injuries in partnership with DND and others. The draft regulations of the *Canadian Forces Members and Veterans Re-establishment and Compensation Act* provide information on mental health care delivery, using multiple providers to:

... involve the use of multiple service providers from different agencies, organizations and private providers of service, with the delivery being coordinated under the direction of a case manager within VAC. For example, for a mental health problem, the medical

¹¹¹ *Canadian Forces Members and Veterans Re-establishment and Compensation Act*, 2005, c.21, <http://laws.justice.gc.ca/en/C-16.8/index.html>.

¹¹² A “rehabilitation need” is a physical or mental health problem resulting primarily from service in the Canadian Forces that is creating a barrier to re-establishment in civilian life.” Government of Canada, *Canada Gazette*, “Canadian Forces Members and Veterans Re-establishment and Compensation Regulations,” Vol. 139, No. 51, 17 December 2005, <http://canadagazette.gc.ca/partI/2005/20051217/html/regle7-e.html>.

¹¹³ The National Mental Health Clinical Centre of Expertise at Ste-Anne de Bellevue is responsible for advances in mental health clinical care through program development, research, education and outreach; Veterans Affairs, *News Release*, “National Mental Health Clinical Centre of Expertise Officially Opens,” 7 November 2005, <http://news.gc.ca/cfmx/view/en/index.jsp?articleid=181199&>.

rehabilitation phase could involve the family physician, a hospital-based psychiatrist, a community mental health team or a VAC-supported private sector therapist. A psychosocial phase may involve an occupational therapist or pain management clinic, and a vocational phase may involve specialized assessment services and training providers.¹¹⁴

On posttraumatic stress disorder and other operational stress injuries, there is ongoing work within the military structure and the civilian medical community. In particular, Veterans Affairs Canada supports the Operational Stress Injury Social Peer Support Program established by DND:

The peer support program is made up of Canadian forces members and veterans across the country who have experienced an operational stress injury themselves, and who want to help others heal and recover. DND has established 13 peer support coordinators located across the country and to date they have helped more than 1400 clients. This network uses a large number of volunteers and we have a brochure we will circulate to the members that shows some of the work volunteers do in helping with these peer support coordinators.
—Brian Ferguson¹¹⁵

13.4.3 Assessments of Client Group Needs

Veterans with mental health concerns constitute a diverse group needing a range of re-establishment programs: transition assistance; job-finding help; rehabilitation; retraining; income support; health care; family assistance; and other elements that encourage independence.

Veterans with mental health concerns constitute a diverse group needing a range of re-establishment programs: transition assistance; job-finding help; rehabilitation; retraining; income support; health care; family assistance; and other elements that encourage independence.

13.4.3.1 Disability Pensions

According to Brian Ferguson, Veterans Affairs Canada aims to provide the same basic approach for aging veterans and for younger veterans with mental health problems:

Former or current peacetime members of the Canadian Forces, reported dissatisfaction with the process for accessing pensions.

¹¹⁴ Government of Canada, *Canada Gazette*, “Canadian Forces Members and Veterans Re-establishment and Compensation Regulations,” Vol. 139, No. 51, 17 December 2005, <http://canadagazette.gc.ca/partI/2005/20051217/html/regle7-e.html>.

¹¹⁵ 23 February, 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

*If they have a pension condition and they require treatment, we pay for it; and we keep track of the treatments that are made on their behalf.*¹¹⁶

However, former or current peacetime members of the Canadian Forces, who, together with survivors and the dependents of military personnel, now form a larger group of disability pension recipients than war service veterans, reported dissatisfaction with the process for accessing pensions. An audit of the Disability Pension Program conducted in 2005 reported that CF clients felt that there was:

... insufficient understanding of the DND culture, including the command structure, and the physical, mental, and emotional stress of military training and deployment to hazardous overseas operating environments.¹¹⁷

At present, the Veterans Review and Appeal Board provides two levels of appeal on disability pension applications as well as a final level of appeal on allowance decisions. In the period between April 2004 and March 2005, the Board heard 6789 claims.¹¹⁸ Clients and other observers noted difficulties in assessing mental disability claims when criteria and standards are not clear and objective. They noted that reporting and record-keeping during periods of conflict may be a low priority, especially for non-life threatening incidents that could have an effect on mental health.

In June 2005, the *Esprit de Corps* magazine issued a press release calling for a Veterans Affairs Canada Ombudsman, similar to the one for the CF, noting that:

The irony is that healthy, (for the most part) employable soldiers in DND have an independent ombudsman while disabled and often unemployable veterans do not.

The irony is that healthy, (for the most part) employable soldiers in DND have an independent ombudsman while disabled and often unemployable veterans do not.

The press release went on to point out the complexities of current disabilities and the resulting low pension awards:

Minimal awards of 20% or \$400/month have been quite common for disabilities that have rendered a veteran unemployable. As a consequence, psychologically and/or physically disabled veterans are forced to enter an indescribably demoralizing review and appeal

¹¹⁶ 23 February, 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹¹⁷ Veterans Affairs Canada, *Volume II of the Disability Pension Program Evaluation*, July 2005, http://www.vac-acc.gc.ca/general/sub.cfm?source=department/reports/deptaudrep/disapen_eval_july2005.

¹¹⁸ Veterans Review and Appeal Board, "About Veterans Review and Appeal Board," <http://www.vrab-tacra.gc.ca/AboutVRAB.htm>.

process, frequently requiring three to five years or more before receiving adequate compensation.¹¹⁹

13.4.3.2 Case Management

The case management approach implemented by Veterans Affairs Canada permits the department to track the development of each client's illness. The goal is to simplify access to existing programs and provide adequate case management services, especially for those who are medically released and often need the most help getting re-established in civilian life. The hope is that case managers will be able to assist people in navigating the maze of providers and benefits that might include Veterans Affairs, National Defence, the Service Income Security Insurance Plan, the Department of Social Development, the Canada Pension Plan disability pension program, the applicable provincial/territorial health care system, and local social assistance avenues.

Case management services could help clients and their families cope with psychological disability and work their way through a complex landscape of programs.

The list of potential service providers is lengthy, the inter-relationship between different programs is complex, and the choices to be made are not always clear. Sometimes, winning benefits from one program results in benefits being clawed back from another. This is administratively cumbersome and gets in the way of best service.¹²⁰

Mr. Ferguson noted how a case manager could simplify the situation facing a client dealing with the loss of income and career. Case management services could help clients and their families cope with psychological disability and work their way through a complex landscape of programs:

A forty-year-old male veteran was pensioned 80% for PTSD related to his service in his special duty area. He is suicidal at times and his wife and children have left home in fear for their own safety. After being discharged from his local hospital, he was faced with a lack of medical resources to help him in his time of need, a familiar refrain. He called Veterans Affairs Canada and spoke to an area counsellor who worked with his local district office staff to explore options. We had to make arrangements with our partners in the United States to get him treatment, but then a local opportunity presented itself. Through our partnerships with DND and local medical practitioners, we were able to get him treatment at the local DND Operational, Trauma and Stress Support Centre, OTSSC. This client will be assisted through case

¹¹⁹ Ombudsman Ontario, "The Case for a VAC Ombudsman — Esprit de Corps," July 2005, http://www.ombudsman.on.ca/PR_details.asp?PRID=174.

¹²⁰ Veterans Affairs Canada- Canadian Forces Advisory Council, *Honouring Canada's Commitment Opportunity with Security for Canadian Forces Veterans and their Families in the 21st Century*, March 2004, <http://www.vac-acc.gc.ca/clients/sub.cfm?source=councils/vaccfac/commitment>.

*management services at the local Veterans Affairs Canada district office to maintain contact with his clinical service providers.*¹²¹

13.4.3.3 Service Provision

Veterans Affairs Canada, like other federal departments with clients experiencing mental health problems, has difficulties accessing mental health services through provincial providers. Mr. Ferguson explained that it is trying to adopt an approach of early intervention to keep mental health situations from growing more serious:

Veterans Affairs Canada has difficulties accessing mental health services through provincial providers.

*Currently VAC, like DND, must compete for scarce acute psychiatric services along with other Canadian citizens. For this reason, we are putting our emphasis on early detection and intervention to detect problems early and prevent acute crisis situations from escalating. Our district office health professionals can intervene on behalf of clients to assist them in receiving the appropriate acute care and monitor their progress after the acute phase.*¹²²

Telehealth is one option that shows promise for the department and its clients. Veterans Affairs Canada, in cooperation with the Memorial University School of Medicine in Newfoundland, is using video-conferencing technology to link clients with professional psychological counselling experts.¹²³

Telehealth is one option that shows promise for the department and its clients.

Dr. Ted Callanan, President, Psychiatric Association of Newfoundland and Labrador, commented on the Veterans' Affairs Canada peer support program and treatment program for those suffering from posttraumatic stress disorders or other conditions related to military service. He noted that, while some choose to come to St. John's where most of the services are located, telehealth has provided options for those living in other areas of the province:

... they can also access their counsellors via telehealth technology now and that is actually proving to be fairly popular. They have worked out some ways around identifying why the different individuals would be coming to the telehealth centre in the small towns and that is moving now into Nova Scotia and going across the country, not as a replacement, but as another means of veterans accessing service.

¹²¹ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹²² 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹²³ Veterans Affairs Canada, *Support for the CF Community*, http://www.vac-acc.gc.ca/clients/sub.cfm?source=salute/osi_edition/cf_support.

13.4.4 Committee Commentary

The Committee is supportive of efforts to overhaul the way that mental health of veterans is assessed and injured veterans are compensated. It commends the increased efforts directed at partnering and the greater coordination of activities between VAC and DND. The establishment of a strong network between the two departments will encourage improvements of services for CF members as well as other clients.

The Committee is supportive of efforts to overhaul the way that mental health of veterans is assessed and injured veterans are compensated. It commends the increased efforts directed at partnering and the greater coordination of activities between VAC and DND.

As with other federal client groups, the Committee is concerned that Parliament may not be aware of the full extent of efforts to assist transition to civilian life and to give disabled veterans a high quality of life.

The Committee therefore recommends:

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| 78 | <p>That Veterans Affairs Canada in conjunction with National Defence prepare an annual inventory of programs and services for mental health, including the number of clients served, the funding allocated and spent, and the outcomes achieved.</p> <p>That the report be tabled in Parliament annually starting in 2008.</p> |
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The Committee is concerned that there is no forum for veterans similar to the Canadian Forces Ombudsman. It sees merit in having an independent and objective body to review and make recommendations on concerns of veterans.

The Committee is concerned that there is no forum for veterans similar to the Canadian Forces Ombudsman. It sees merit in having an independent and objective body to review and make recommendations on concerns of veterans.

The Committee recommends:

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

... traditional policing practices do not work in the way they are meant to work in dealing with people who are in a mental health crisis.
—Shirley Heafey, Chair of the RCMP Public Complaints' Commission¹²⁴

13.5.1 Federal Responsibility

Under the *Canada Health Act*, “a member of the Royal Canadian Mounted Police who is appointed to a rank” is excluded from the definition of “insured persons.” The Royal Canadian Mounted Police is organized under the authority of the *Royal Canadian Mounted Police Act*,¹²⁵ which sets out the qualifications required for being a member of the RCMP. The *Royal Canadian Mounted Police Regulations* outline the basic conditions for regular members or special constable members to have access to health services, subject to approval by the Commissioner.¹²⁶ As of 31 March 2005, the Force had 22,557 employees, including regular and civilian members and public service employees.¹²⁷

The *Royal Canadian Mounted Police Regulations* contain several specific provisions that deal with mental health issues as a disability, although they do not distinguish between an incapacity that is work-related and one that is not. With respect to administrative discharges, “a member, other than an officer, may be discharged from the Force, and it may be recommended that an officer be discharged from the Force, on any of the following grounds, namely, (a) physical or mental disability after consideration by a medical board.”

Royal Canadian Mounted Police members who have become disabled as the result of Special Duty Service,¹²⁸ and who have consequently been released or discharged from the RCMP are entitled to be appointed ahead of others to positions in the public service for which they are qualified.¹²⁹ Also, after discharge or compulsory retirement, the *Royal Canadian Mounted Police Superannuation Act* specifies that a recipient of supplementary benefits can be

a person who, not having reached sixty years of age, is in receipt of a pension as a result of having been compulsorily retired from the

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

¹²⁵ *Royal Canadian Mounted Police Act*, R.S. 1985, c. R-10, <http://laws.justice.gc.ca/en/R-10/index.html>.

¹²⁶ *Royal Canadian Mounted Police Regulations*, 1988 (SOR/88-361) <http://laws.justice.gc.ca/en/R-10/SOR-88-361/174146.html>.

¹²⁷ Royal Canadian Mounted Police, *Departmental Performance Report for the period ending March 31, 2005*, p. 23, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/RCMP-GRC/RCMP-GRCd4502_e.asp#glance.

¹²⁸ Special Duty Service involves designated operations which could include armed conflict, peacekeeping missions, anti-terrorism activities, disaster relief or search and rescue activities.

¹²⁹ Public Service Commission, *Guide to the Priority for Members of the CF and RCMP who become Disabled*, http://www.psc-cfp.gc.ca/staf_dot/priority-priorite/rcmp-grc_e.htm.

Force by reason of any mental or physical condition rendering the person disabled,¹³⁰

In 2003 Veterans Affairs Canada undertook responsibility for administering the RCMP disability pension and health care benefits for RCMP members who are pensioned for service-related injuries and illnesses. It assumed responsibility for the direct payment of disability pensions for approximately 3,800 RCMP pensioners as well as the provision of health care benefits for approximately 800 retired and civilian pensioners.¹³¹ By early 2005, it was estimated that VAC delivered benefits and services to more than 5,000 RCMP clients, including 300 pensionable survivors of RCMP members.¹³²

13.5.2 Federal Programs and Services

The RCMP External Review Committee was established in 1988 to provide impartial reviews of certain grievances as well as appeals relating to formal disciplinary measures. Upon completing its review of a case, the External Review Committee presents recommendations to the Commissioner of the RCMP, who is the final decision-maker, but who must provide reasons if he disagrees with the Committee in any given case.

Various reports of the External Review Committee yielded information about the mental health, mental illness and addiction concerns of RCMP members, including increased sick time, impaired work performance, and alcohol dependency as outcomes associated with increased stressors for RCMP members.¹³³ In some cases of dismissal for conduct deemed disgraceful that were reviewed by the RCMP External Review Committee, stress-related incidents led to recommendations ranging from orders to voluntarily resign or be dismissed to medical discharge on grounds of mental disability.

Lack of training in dealing with public manifestations of mental illness is also endemic to the internal workings of the RCMP.

The judge stated that RCMP training to deal with mentally ill people varied from non-existent to less than adequate.
— Shirley Heafey

Several witnesses spoke to the Committee about the lack of sensitivity exhibited by RCMP officers dealing with mentally ill individuals in the community. They also suggested that lack of training in dealing with public manifestations of mental illness is also endemic to the internal workings of the RCMP. In this regard, Shirley Heafey, Chair of the RCMP Public Complaints' Commission told the Committee:

In 2003, during the course of a judicial inquiry into the RCMP shooting death of a person in a mental health crisis, the judge stated that RCMP

¹³⁰ Royal Canadian Mounted Police Superannuation Act, R.S. 1985, c. R-11, <http://laws.justice.gc.ca/en/R-11/text.html>.

¹³¹ Royal Canadian Mounted Police, "Veterans Affairs Canada and the Royal Canadian Mounted Police Partner to Improve Services," *RCMP News Release*, 17 February 2003.

¹³² RCMP, "The New Veterans Charter — Chief Human Resource Officers Message," 24 May 2005, http://www.rcmp.ca/vets/new_charter_e.htm#top.

¹³³ Royal Canadian Mounted Police External Review Committee, Publications, including research reports and communiqués about individual cases, http://www.erc-ccc.gc.ca/english/publications_date.html.

*training to deal with mentally ill people varied from non-existent to less than adequate, and that all three RCMP incident officers welcomed the idea of more and better training in this area.*¹³⁴

Doris Ray told the Committee of her experience as a family member:

*The officer confided that he had learned about the symptoms of schizophrenia through his brother-in-law who suffered from the disease. His training in the RCMP, most often the first line of defence for families in crisis situations, especially in small towns, included very little training in recognizing and dealing with symptoms of psychosis. I recently inquired of a young officer if he had had any more training in that line and he said they now receive even less training than in years past.*¹³⁵

In general, the RCMP provides comprehensive health services to ensure that regular members are emotionally and medically fit to perform their duties. Should a serving member of the RCMP use services provided by a given province, they present their client registration number which ensures that authorization is obtained from an RCMP Health Services Officer; the provincial service then bills the RCMP. Each RCMP division usually has a physician as regional health services officer, together with a regional psychologist and a variable number of occupational health nurses.

A study in 1992 identified three general sources of occupationally-linked police stress that can lead to such common mental health symptoms as depression, burnout and suicide:¹³⁶

Police officers may be hampered by a belief that admitting to problems and seeking help suggests weakness.

- external stressors linked to factors such as court appearances, cross-examinations, lengthy judicial decisions, lack of encouragement from the public, relations with minority groups and the general mass-media image of police;
- internal stressors related to police organization and structure such as lack of participation in work organization, communication problems, insufficient support from superiors, and excessive bureaucracy, training, performance evaluation, salary, promotion, inadequate human and material resources; and
- task-related stressors such as work overload alternating with periods of inactivity, role conflicts and ambiguities, perception of danger, task complexity, lack of autonomy, ambiguous feelings and the responsibility of facing misery, pain and death.

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

¹³⁵ 6 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/18eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹³⁶ Royal Canadian Mounted Police External Review Committee, *Occupational Health and Safety- An Employer Perspective*, Discussion Paper 9, 1992, <http://www.erc-ccc.gc.ca/Discussion/english/eDP9.htm>.

This study revealed a relationship between occupational stressors and reductions in productivity, increases in reaction time and judgement errors, work dissatisfaction, the desire to quit, absenteeism and accidents.¹³⁷ Another report on Employee Assistance Programs emphasized the difficulty in implementing assistance programs in the policing sector where police departments operate as a “closed society.” Also, police officers may be hampered by a belief that admitting to problems and seeking help suggests weakness.¹³⁸

When the RCMP recruit psychologists, they try to hire them at “\$20- to \$30,000 less than what the hospital down the street is paying.”

Services available to RCMP officers through the RCMP Health Services are variable. Health services officers generally act as case managers — providing assessment, referral and follow-up for such things as treatment and rehabilitation programs for substance abuse and related personal problems.¹³⁹ Dorothy Cotton, Co-chair/Psychologist, Canadian National Committee for Police/Mental Health Liaison, pointed out that when the RCMP recruit psychologists, they try to hire them at “\$20- to \$30,000 less than what the hospital down the street is paying.” She insisted that “you cannot hire people for that kind of money. It also speaks to what they think of the profession.”¹⁴⁰

13.5.3 Assessments of Client Group Needs

The RCMP recently announced its recognition as one of the country’s top employers in the 2006 edition of *Canada’s Top 100 Employers*.¹⁴¹ Its own surveys of performance in 2003-2004, however, identified problems with morale, work environment, communications, tools and training, workload, responsibility and support systems. The survey reported “overall employee satisfaction: 61%; although employees are proud of our organization and the work they do, there were numerous issues regarding workload, fairness and career development.”¹⁴²

The RCMP was not included in the New Veterans Charter and thus was excluded from the proposals for change to Veterans Affairs Canada programs and services aimed at CF clients.

In 2002, Norman Sabourin, Executive Director and Senior Counsel for the External Review Committee, wrote an article titled “Medical Discharge and the Duty to accommodate in the RCMP.” In his conclusion, he argued that “the Force will have to find a suitable position for

¹³⁷ *Ibid.*

¹³⁸ Royal Canadian Mounted Police External Review Committee, *Employee Assistance Programs — Philosophy, theory and practice*, Discussion Paper 5, 1990, <http://www.erc-ccc.gc.ca/Discussion/english/eDP5.htm>.

¹³⁹ Health Canada, *Profile — Substance Abuse Treatment & Rehabilitation in Canada*, “The federal role in substance abuse treatment,” 1999, http://www.hc-sc.gc.ca/ahc-asc/pubs/drugs-drogués/profile-profil/federal_e.html.

¹⁴⁰ 16 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/06eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁴¹ RCMP, *News Release*, “RCMP Named One of Canada’s Top 100 Employers,” 18 October 2005, http://www.rcmp-grc.gc.ca/news/n_0524_e.htm.

¹⁴² RCMP, *Departmental Performance Report 2003-2004*, http://www.tbs-sct.gc.ca/rma/dpr/03-04/RCMP-GRC/RCMP-GRCd3401_e.asp#Lines.

a member with an impairment who wishes to continue working, or else demonstrate that it would face undue hardship by doing so.” He emphasized that “this will require significant changes to existing policies.”¹⁴³

For RCMP members, there is a disparity between the disability services and benefits available to them and those available to other clients served by Veterans Affairs Canada. For example, the RCMP do not have access to the Veterans Independence Program services (home care, home adaptations, transportation, ambulatory health care and nursing home care). Veterans Affairs Canada indicated that it is prepared to consider ways of addressing some of the gaps in services:

To date, research undertaken in collaboration with the RCMP reveals that, while not necessarily sharing the same views, attitudes and mind-set as CF clients, the RCMP understand and appear to relate well to CF issues and concerns. This is, no doubt, linked to both groups having worked in/been exposed to similar situations and environments, including peacekeeping/SDA deployments. In order to adequately address gaps in services/benefits, training will be required for VAC staff to increase their general understanding of the RCMP and the ‘police’ culture.¹⁴⁴

However, the RCMP was not included in the New Veterans Charter and thus was excluded from the proposals for change to Veterans Affairs Canada programs and services aimed at CF clients. Instead, the RCMP indicated that it would do its own assessment of needs:

The RCMP has opted to conduct an assessment of its still-serving and retired members’ needs for modernized services and programs. This assessment is necessary as there are considerable differences in the profiles, roles, career paths and qualifications of today’s RCMP and CF members. Consequently, the needs of RCMP members may be quite different than those of CF members.¹⁴⁵

Several RCMP veterans’ associations reported on correspondence from the RCMP Commissioner stating that a Task Force on the Modernization of Disability Programs and Services had been established to oversee a comprehensive needs analysis. The assessment was to look at both the service by RCMP under the *Pension Act* and the access to long term care and in-home independence benefits (Veterans Independence Program) that go beyond those available in the Attendance Allowance.¹⁴⁶ Claiming other priorities, the RCMP had already delayed this needs analysis from previous years and, although expected to be reported in the fall of 2005, it was not available to the public by early 2006.

¹⁴³ Norman Sabourin, “Medical Discharge and Duty to Accommodate in the RCMP,” External Review Committee, March 2002, http://www.erc-ccc.gc.ca/english/articles/articles_medicaldischarge.html.

¹⁴⁴ Veterans Affairs Canada, *Putting Our Priorities into Action, Five year Strategic Plan — Update 2004*, <http://www.vac-acc.gc.ca/general/sub.cfm?source=department/reports/update2004/action04>.

¹⁴⁵ RCMP, “The New Veterans Charter — Chief Human Resource Officers Message,” 24 May 2005, http://www.rcmp.ca/vets/new_charter_e.htm#top.

¹⁴⁶ RCMP Veteran’s Association, Calgary Division, “Notes of Interest,” <http://www.members.shaw.ca/rcmpvets.calgary/notes.htm>.

13.5.4 Committee Commentary

The Committee is aware of the efforts by the RCMP to address the needs of its officers who pursue disability claims, some of them related to mental health issues. Nevertheless, more readily available public information on this federal client group is needed.

The Committee is unaware of the training provided to RCMP officers to increase their understanding of mental illness.

The Committee wants to know if the RCMP provides counselling to employees after a traumatic situation or to them and their families during and after a stressful relocation. It is also interested in ways to address the

The Committee wants to know if the RCMP provides counselling to employees after a traumatic situation or to them and their families during and after a stressful relocation. It is also interested in ways to address the particular transition needs of RCMP members who are being discharged and determine what adjustments may be required to legislation, health care policies and programs, and service delivery mechanisms to ensure their appropriate access to services.

particular transition needs of RCMP members who are being discharged and determine what adjustments may be required to legislation, health care policies and programs, and service delivery mechanisms to ensure their appropriate access to services.

In addition, the Committee is unaware of the training provided to RCMP officers to increase their understanding of mental illness. Witnesses suggest that it is limited or non-existent. Incorporating training about mental health and addictions can enhance not only officers' ability to deal with the public but also their ability to understand facets of mental illness among their colleagues within the Force itself.

The Committee recommends:

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

The Committee is pleased that the RCMP has established an External Review Committee to undertake investigations into specific issues. This body appears to be well-placed to conduct more analysis of the mental health needs of RCMP members.

The Committee recommends:

81	That the RCMP External Review Committee do an analysis of the mental health needs of RCMP members and RCMP veterans and report to Parliament by 2007.
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13.6 IMMIGRANTS AND REFUGEES

The mental health system recognizes the need to address posttraumatic syndrome, but fails to recognize that, until racism is addressed, which is the trauma refugees and new immigrants experience on a daily basis, such an approach will be ineffective. —Martha Ocampo, Co-Director, Across Boundaries, Ethnoracial Mental Health Centre, Toronto¹⁴⁷

13.6.1 Federal Responsibility

Citizenship and Immigration Canada (CIC) is responsible for the admission into Canada of immigrants, foreign students, visitors, temporary workers and refugees. As described by Dr. Sylvie Martin, Acting Director, Immigration Health Program Elaboration, Medical Services Branch, Citizenship and Immigration Canada.

All applicants for permanent residence and some for temporary residence (e.g. visitors, students and workers) undergo a physical and mental examination.

Under the Immigration and Refugee Protection Act and its regulations, the department admits temporary residents and immigrants who contribute to the economic and social growth of Canada, it provides resettlement, protection and a safe haven to refugees, it assists newcomers to adapt to Canadian society and eventually obtain citizenship, and it manages access to Canada in order to protect the security and health of Canadians as well as the integrity of Canadian laws.¹⁴⁸

Under the *Immigration and Refugee Protection Act*, all applicants for permanent residence and some for temporary residence (e.g. visitors, students and workers) undergo a physical and mental examination.¹⁴⁹ Based on this examination, applicants may be refused entry into Canada if they have a physical or mental health condition that is considered likely to be a danger to public health or safety, or that could be very demanding on health or social services. Information from the Department is not specific about possible responses to applicants who are living with mental disorders.

¹⁴⁷ 17 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/07ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁴⁸ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁴⁹ *Immigration and Refugee Protection Act*, 2001, c. 27, <http://laws.justice.gc.ca/en/I-2.5/>.

The term, “excessive demand,” refers to “the burden placed on Canada’s health or social services due to ongoing hospitalization or medical, social or institutional care for physical or mental illnesses, or special education or training.”¹⁵⁰ To determine if an applicant will likely create such excessive demand, a departmentally-designated Medical Officer will consider

After admission to Canada, the expectation is that the delivery of programs and services related to mental health that fall into the public health care sphere will be a responsibility of the provinces and territories.

the diagnosis, prognosis, and the health and/or social service needs of the individual concerned over a period of time (usually five years). The Medical Officer will then assess the anticipated costs of these needs over a five year period *and* determine if there are waiting lists for any of the necessary services. If the anticipated costs exceed the average Canadian’s per capita health and social services costs over five years, or if there are waiting lists for any of the necessary services, the applicant will be deemed inadmissible.¹⁵¹ Certain groups defined in section 38(2) of the *Immigration and Refugee Protection Act* receive an “excessive demand exemption” and will not be refused entry based on possible health demands.¹⁵²

After admission to Canada, the expectation is that the delivery of programs and services related to mental health that fall into the public health care sphere will be a responsibility of the provinces and territories. This is dependent, however, on variables such as the length of time it takes for federal processing of a claimant’s application and the nature of the agreement between the federal government and a province or territory with respect to settlement and integration services. Landed immigrants are expected (but do not always manage) to arrange their own health care, including private insurance to cover the 3 month waiting period for coverage imposed in four provinces (British Columbia, Ontario, Quebec and New Brunswick).¹⁵³

In the department’s 2005 performance report to Parliament, Citizenship and Immigration Canada indicated that a total of 235,824 people were admitted to Canada as permanent residents in 2004.⁽¹⁵⁴⁾ Of the newcomers admitted, the department noted that:

- 57% (133,746) were economic immigrants and their dependants;

¹⁵⁰ Citizenship and Immigration Canada, *Applying for Permanent Residence*, “Appendix D: Medical Examinations,” 2004, <http://www.cic.gc.ca/ENGLISH/pdf/kits/guides/4000E.PDF>.

¹⁵¹ Correspondence from Dr. Sylvie Martin, Acting Director, Immigration Health Program Elaboration, Medical Services Branch, Citizenship and Immigration Canada to Senator Michael Kirby, Chair, Standing Committee on Social Affairs, Science and Technology, The Senate, 3 February 2006.

¹⁵² Family class sponsored spouses, common-law partners, conjugal partners and their dependent children, and convention refugees and persons in need of protection and their dependents, will not be refused entry if they have a health condition that places excessive demand on health or social services; CIC, *Medical Testing and Surveillance*, Fact Sheet 20, <http://www.cic.gc.ca/english/irpa/fs%2Dmedical.html>.

¹⁵³ Anita Gagnon, *Responsiveness of the Canadian Health Care System Toward Newcomers*, Discussion Paper no.40, Commission on the Future of Health Care in Canada, November 2002, http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/40_Gagnon_E.pdf.

¹⁵⁴ Citizenship and Immigration Canada, *Departmental Performance Report for the period ending March 31, 2005*, p. 61, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/CI-CI/CI-CId45_e.pdf.

- 26% (62,246) were in the family class;
- 14% (32,685) were refugees and other protected persons;
- 3% (6,945) were granted permanent resident status on humanitarian and compassionate grounds.

13.6.2 Federal Programs and Services

13.6.2.1 Interim Federal Health Program

Citizenship and Immigration Canada's direct role in the provision of mental health services is through the Interim Federal Health Program. This program originated with a 1957 Order-in-Council and was moved from Health Canada to Citizenship and Immigration Canada in 1995. As Dr. Martin indicated:

... it offers health services to migrants, currently refugee claimants, refugees, detainees in immigration detention centres and failed refugees still in Canada who are unable to pay for their health care services. It covers essential and emergency medical services, including mental health services such as consultation with physician, hospitalization and essential medication. The overall budget for this program was \$51 million in 2002-2003, with 97,000 users and 700,000 claims.¹⁵⁵

The program is administered by FAS (Funds Administrative Service Inc.) Benefit Administrators in Edmonton. Mental health services covered under the Interim Federal Health Program are limited but do include: consultations with a psychiatrist, hospitalization for psychiatric disorders, initial psychotherapy session with a physician (follow up covered if approved) and essential medication.

Citizenship and Immigration Canada's direct role in the provision of mental health services is through the Interim Federal Health Program.

The department did not provide a breakdown of expenditures that relate to mental illness or addiction. It is reasonable to assume, however, that these could be significant, given that many refugee claimants have been victims of torture and have endured other strains on their mental health.

Some provinces have raised concerns about the adequacy of the Interim Federal Health program to meet the overall costs of immigration-related medical and health services. They have asked for reviews of levels of permitted fees, scope of covered services, and reimbursement of provincial costs incurred for service provision. For example, the 2004 British Columbia accord authorized under the *Immigration and Refugee Protection Act* points to the need for consideration of provincial costs incurred in providing services for refugee claimants; for immigrants deemed to be medically inadmissible who are allowed to proceed to Canada under new legislation (excessive demand exemption), and for people admitted

¹⁵⁵ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

with serious health problems during the three (3) month waiting period for British Columbia's Medical Services Plan coverage.¹⁵⁶

13.6.2.2 Other Initiatives

Dr. Martin pointed out that the department also has other initiatives designed to contribute positively to the mental health of newcomers to Canada:

If mental health is defined as each person's ability to experience, reflect and act in such a way as to obtain the greatest enjoyment from life and to cope with different challenges, it can be said that Citizenship and Immigration Canada is responsible for a number of initiatives that are either directly or indirectly linked to mental health.

Several of our programs are aimed at facilitating and improving the social, cultural and economic integration of newcomers, thus reducing the stress involved in settling in a new country for the benefit of such newcomers.

These different programs provide information relating to existing resources and facilitate the access to such services.¹⁵⁷

Citizenship and Immigration Canada attempts to ease the stress of integrating into Canadian society through several programs:

- The Immigrant Settlement and Adaptation Program funds service provider organizations to provide counselling and non-therapeutic services to newcomers, including referrals to services for educational, legal, social and health needs as well as employment and housing.
- The Host Program funds the recruitment, training, matching and coordination of volunteers who can help newcomers to deal with educational and health issues and to learn about and access available services in their community.
- The Resettlement Assistance Program provides income support and a range of immediate services. For the regular stream of government-assisted refugees, the department provides up to 12 months of income support; for those with special needs, this can be extended to 24 months. The amounts are guided by provincial social assistance rates.

Citizenship and Immigration Canada is also involved in other partnership arrangements at different levels. For example, it supports the Canadian Centre for Victims of Torture and the Metropolis project, a national/international forum for research and policy on migration. In addition, the F/P/T Working Group on Settlement and Integration discusses issues of a

¹⁵⁶ Citizenship and Immigration Canada, *Agreement for Canada-British Columbia Cooperation on Immigration*, "Annex H — Immigration Health," <http://www.cic.gc.ca/english/policy/fed-prov/bc-2004-annex-h.html>.

¹⁵⁷ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

multilateral nature. Interdepartmentally, there are joint initiatives with the Public Health Agency of Canada on migration health challenges, as well as with Industry Canada, Human Resources and Skills Development Canada and Health Canada on informational projects to facilitate integration.

Citizenship and Immigration Canada is also responsible for various linguistic programs including the Language Instruction for Newcomers to Canada Program that provides basic language instruction to adult immigrants to help them integrate successfully.

13.6.3 Assessments of Client Group Needs

Individuals who enter Canada as immigrants and refugees constitute a heterogeneous group. Some come to this country under an economic or a family category, some as refugees and others as asylum seekers. Some arrive having already received permission to live in Canada permanently while others arrive requesting acceptance as refugees. Regardless of the category, immigrants and refugees are newcomers to Canada carrying multiple experiences that shape how they will adapt to their new country.

In many towns, no language program or support services exist for immigrants, leaving them without access to resources that would enhance their mental health.

Even when people take language classes, they are not necessarily able to communicate their mental health needs, especially since language education is often geared primarily to individuals destined for the labour market.

Sister Mangalam Lena, a Franciscan Nun from Ottawa, spoke to the Committee on behalf of immigrants and refugees. Sister Lena, who is also a hospital chaplain and nurse as well as being a home-based spiritual care provider, talked of the many factors such as “loneliness” and “uprootedness,” “woundedness” and “brokenness,” that can affect a person’s mental health. She described a program, initiated by immigrants themselves, that allows them to share their stories one-on-one. She explained:

Journeying with these immigrants, we know that many of them from these war countries have seen atrocities, they have seen their loved ones being killed and they have seen their mothers and sisters raped. In this new program, we see how creating a safe environment has brought them peace of mind and comfort.¹⁵⁸

The separation from family and community, combined with the inability to speak English or French, can contribute not only to serious emotional distress but also to reduced access to needed services. Although language programs may be in place, not everyone has access to them.

Over time, the underutilization of services by newcomers could prove very costly to the health care system.

In many towns, no language program or support services exist for immigrants, leaving them without access to resources that would enhance their mental health. Moreover, even when people take language classes, they are not necessarily able to communicate their mental

¹⁵⁸ 21 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/23eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

health needs, especially since language education is often geared primarily to individuals destined for the labour market.

Raymond Chung, Executive Director, Hong Fook Mental Health Association, Toronto called for mandatory guidelines to be made available as required on the funding, training and service delivery model of trained mental health interpreters.¹⁵⁹ He stressed that, over time, the underutilization of services by newcomers could prove very costly to the health care system:

*It is only through ethnocultural, language-specific mental health prevention and promotion strategies that we can achieve the goal of early identification and early intervention. In turn, you will help to reduce the financial and human costs in our society and, in the long run, for treating more serious mental illnesses.*¹⁶⁰

Others witnesses observed how certain individuals, especially elderly persons and women from traditional cultures, are also more likely to experience difficulties during resettlement. Steve Lurie, Executive Director of the Canadian Mental Health Association, Toronto, pointed out that immigrant women with mental health problems need particular attention.¹⁶¹

Robena Sirett, Manager, Older Persons Adult Mental Health Services, Vancouver, indicated that there are knowledge gaps about the elderly victims of trauma or torture who come to Canada as refugees.

*We are trying to develop programs that can be more responsive and flexible, depending on the refugees that are coming to our city...we did not have that cross-cultural competence where we could go in and work with them.*¹⁶²

Racism may be one reason why eligible immigrants and refugees underutilize health services. Underutilization may be also result from fear that using mental health services could jeopardize ongoing immigration applications. As well, language barriers, experiences with culturally inappropriate care, or difficulties in navigating the health system can discourage people from using the services that are available.¹⁶³

Underutilization may be also result from fear that using mental health services could jeopardize ongoing immigration applications.

¹⁵⁹ 17 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/07ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁶⁰ 17 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/07ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁶¹ 17 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/07ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁶² 8 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/20ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁶³ Anita Gagnon, *Responsiveness of the Canadian Health Care System Toward Newcomers*, Discussion Paper no.40, Commission on the Future of Health Care in Canada, November 2002, http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/40_Gagnon_E.pdf.

Martha Ocampo emphasised how the overall mental as well as physical health of newcomers, as for other Canadians, is strongly influenced by their social environment. Racism in combination with poverty, unemployment, inadequate housing and limited community support can all affect their successful integration, as can their relationship with those providing mental health services. Ms. Ocampo told the Committee:

*The mental health of members from racialized communities cannot be understood in isolation from the social conditions of their lives. These conditions are characterized by social inequities which influence the type of mental health problems people from these communities develop and impact on how these problems are understood and treated by health professionals and the mental health system.*¹⁶⁴

For Ms. Ocampo, the key to full participation is accommodation:

*... you must remember that new immigrants or refugees are trying to settle and will need certain accommodations in order for them to participate fully. If the issue is child care or transportation expenses, there are many things that you have to consider.*¹⁶⁵

13.6.4 Committee Commentary

The Committee acknowledges that Canada is regarded as a safe refuge for many of the increasing number of immigrants and refugees seeking to enter the country. But Canada's commitment to provide this safe refuge *must* include assurances that individuals have access to health services to help them deal with any mental health issues they face.

Canada's commitment to provide this safe refuge *must* include assurances that individuals have access to health services to help them deal with any mental health issues they face.

As with other federal client groups, the Committee has identified a role for an external body to provide oversight and assessment of how well the federal government is meeting its commitments to immigrants and refugees.

Thus, the Committee recommends:

¹⁶⁴ 17 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/07ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁶⁵ 17 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/07ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

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- 82 **That the federal government establish an entity for immigrants and refugees, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee;**
- That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of immigrants and refugees;**
- That this entity provide an annual report to Parliament.**

The Committee supports greater involvement of immigrant and refugee communities as partners in research, program development and services delivery. There is a need for more Canadian research into the identification and evaluation of culturally appropriate systems of care for immigrant populations, particularly in relation to such vulnerable populations such as children, women and seniors.

There is a need for more Canadian research into the identification and evaluation of culturally appropriate systems of care for immigrant populations, particularly in relation to such vulnerable populations such as children, women and seniors.

Language is a key tool to facilitate successful integration and positive mental health among immigrants and refugees. All immigrants and refugees should have equal access to official language education. The federal government has an obligation to provide and pay for linguistically and culturally appropriate services; it must not offload them onto the provinces.

The Committee recommends:

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

13.7 FEDERAL PUBLIC SERVICE EMPLOYEES

As the country's largest employer, I want to assess what the federal government is doing to address mental health issues in the workplace. Simply stated, we need to be a leader and example for employers across the country. — The Honourable Ujjal Dosanjh, former Minister of Health.¹⁶⁶

13.7.1 Federal Responsibility

Through the authority of the *Financial Administration Act*, Treasury Board is the employer of the federal public service and responsible for labour relations, pensions and benefits, as well as employee and military compensation.¹⁶⁷ Other legislation also impacts on the working conditions of federal employees. For example, the *Employment Equity Act* requires federal employers to provide reasonable accommodation for persons with disabilities,¹⁶⁸ while the *Government Employees Compensation Act* authorizes compensation for loss of earnings, medical care and other related benefits to federal employees with employment-related injury or disability.¹⁶⁹

According to the 2005 departmental performance report for the Treasury Board of Canada Secretariat:

The federal public sector is the largest organization in Canada. With over \$200 billion in expenditures, it is seven times larger than any other enterprise in the country. With 450,000 employees, 200 organizations, 400 million transactions a year and 1,750 points of service, it is arguably the most complex institution in Canada.¹⁷⁰

13.7.2 Federal Programs and Services

The majority of federal public service employees rely on the governments of the provinces or territories in which they work for essential mental health services. In its role of employer, the Treasury Board sets policies that govern the public service health care and the disability insurance plans for departmental and agency employees under its authority. These plans cover the cost of services and other benefits for mental health not available through other insurance plans.

The majority of federal public service employees rely on the governments of the provinces or territories in which they work for essential mental health services.

The Public Service Health Care Plan (PSHCP) applies to Public Service employees, members of the Canadian Forces (CF), members of the Royal Canadian Mounted Police (RCMP),

¹⁶⁶ Public Health Agency of Canada, *News Release*, “Michael Wilson to serve as Special Ministerial Advisor on Mental Health,” 4 February 2005.

¹⁶⁷ *Financial Administration Act*, R.S. 1985, c. F-1, <http://laws.justice.gc.ca/en/f-11/text.html>.

¹⁶⁸ *Employment Equity Act*, 1995, c.44, <http://laws.justice.gc.ca/en/e-5.401/50293.html>

¹⁶⁹ *Government Employees Compensation Act*, Chapter G-5, <http://laws.justice.gc.ca/en/g-5/63537.html>.

¹⁷⁰ Treasury Board, *Performance Report for the period ending March 31, 2005*, p. 13, http://www.tbs-sct.gc.ca/rma/dpr1/04-05/TBS-SCT/TBS-SCTd45_e.pdf.

pensioners, and their respective dependants.¹⁷¹ A PSHCP Directive notes, however, that only eligible dependents of members of the CF and RCMP are covered; the members themselves are covered under their own specific plans.¹⁷² The Plan reimburses participants for all or part of costs incurred for eligible services, only after they have taken advantage of benefits provided by the relevant provincial/territorial plans. The extended health provision includes coverage for services provided by a psychologist and prescribed by a physician up to \$1,000 in a calendar year.

According to Phil Charko, Assistant Secretary, Pension and Benefits Division, Treasury Board Secretariat, in one year, the federal government paid out an estimated \$64 million for prescribed drugs and \$10 million on psychological services under the Public Service Health Care Plan.¹⁷³

In one year, the federal government paid out an estimated \$64 million for prescribed drugs and \$10 million on psychological services under the Public Service Health Care Plan.

The Disability Insurance Plan is designed to give Public Service employees a measure of income protection. It provides for a monthly income benefit for employees who are unable to work for a lengthy period of time because of a totally disabling illness or injury. Income replacement during long-term disability can be up to 70% of an individual's annual salary. Benefits are payable for up to 24 months if the individual is totally disabled (i.e. in a continuous state of incapacity due to illness or injury, prevented from performing regular occupational duties). If, at the end of this 24-month period, the disability continues to prevent the performance of a commensurate occupation requiring similar qualifications, the benefit can be continued up to age 65 years.¹⁷⁴

In 2003, 44 percent of new long-term disability cases were for anxiety and depression. He noted that this was “a fairly high number” but stressed that there is also a fairly high rate of recovery and return to work.

Mr. Charko pointed out that, in 2003, 44 percent of new long-term disability cases were for anxiety and depression. He noted that this was “a fairly high number” but stressed that there is also a fairly high rate of recovery and return to work. He suggested that approximately 70% of people who go on long-term disability return to work in the public service. According to him, the return to work involved:

... a flexible approach whereby individuals can come back temporarily in a less demanding job or can come back on reduced hours. If they are coming back

¹⁷¹ Treasury Board of Canada Secretariat, *Public Service Health Care Plan — Benefits Coverage and Plan Provisions*, July 2001, http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/TB_862/pshcpb-rssfpp_e.asp.

¹⁷² Treasury Board of Canada, *Public Service Health Care Plan Directive*, April 2005, http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/TB_862/pshcp_e.asp.

¹⁷³ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁷⁴ Treasury Board Secretariat, *Chapter 3-4, Long-term Disability*, http://www.tbs-sct.gc.ca/Pubs_pol/hrpubs/TB_865/CHAP3_4-PR_e.asp?printable=True.

on reduced hours, the [disability insurance] benefit is continued to the point where they are back to their main income.¹⁷⁵

For Mr. Charko, the successful management of mental health issues in the federal public services entails three factors:

If you have managers that are focused on [human resource] issues and well trained, that is one success factor. If you have a suite of work place policies that deal with leave and duty to accommodate employees with mental health problems, that is another success factor. The third deals with your insurance programs when in fact the employee finds himself in difficulty.¹⁷⁶

Mr. Charko indicated that a comprehensive set of workplace policies to assist federal employees and address issues such as mental health and addiction problems and work place well-being should:

... include things like flexible working arrangements, telework, job sharing, mobility policies, child care. We have generous leave policies, anti-harassment, fitness, duty-to-accommodate policies, employment equity, pride and recognition, and policies with respect to the code on values and ethics.¹⁷⁷

In relation specifically to the employee assistance program, Mr. Charko noted that it is mandatory in all government departments:

It provides for short-term confidential counselling. It is paid for by the department and allows for counselling of employees with all kinds of problems, not just mental health, without prejudice to job security or career.¹⁷⁸

13.7.3 Assessments of Client Group Needs

Federal government employees are located in every province and territory and work in communities of every size. They do many things: inspect food, report weather conditions, patrol fisheries, guard borders, staff correctional institutions, conduct scientific research, issue passports, assist in travel abroad, monitor infectious diseases, and have multiple other responsibilities.

While the federal government's policy framework to support its employees and to create workplaces conducive to their wellbeing seems appropriate, reports of actual experience with the individual programs and policies suggest that there are still many unresolved issues.

¹⁷⁵ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁷⁶ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁷⁷ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁷⁸ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Over the last decade, a number of factors that contribute to making federal workplaces more stressful present significant challenges to both the physical and mental health of federal employees. These include the cumulative affect of downsizing, restructuring, and devolution of authority, as well as constrained resources and intense media scrutiny in the wake of a variety of controversies and scandals.

This increase in stress at the workplace is illustrated by the results of internal surveys conducted by Treasury Board Secretariat.¹⁷⁹ Significant numbers of survey respondents reported being pressured in their jobs and confused by constantly changing priorities. Respondents indicated that they are experiencing instability in their departments and are being left out of decision-making processes in areas that directly affect their work. Twenty-one percent reported having been the victims of harassment, and 17% reported having been discriminated against in the workplace.

The National Joint Council, a body that includes public service bargaining agents and Treasury Board representatives, strives to find collaborative solutions to workplace problems. It reported that the Disability Insurance Plan delivered \$223 million in 2004 in support to affected employees. The Council pointed out that:

Psychological conditions including stress and anxiety remained the major cause of disability for new claims in 2004 as it has in the last thirteen (13) years. Increasingly cases presented deal less with objective verifiable medical data verified by traditional diagnostic protocols and more with the challenges that are posed by the difficulty of diagnosing these illnesses.¹⁸⁰

Mr. Charko asserted that a work place in which individual differences are respected “can do a lot to eliminate the stigma associated with mental illness which is a problem in the public service.” In this regard, the Treasury Board Secretariat has developed a Policy on the Duty to Accommodate Persons with Disabilities in the Federal Public Service¹⁸¹ in response to a requirement of the *Employment Equity Act* that employers provide reasonable accommodation for persons with disabilities. The guideline definition of persons with disabilities that accompany this policy includes individuals who suffer from a “long-term or recurring physical, mental, sensory, psychiatric, or learning impairment.”¹⁸²

While the federal government’s policy framework to support its employees and to create workplaces conducive to their wellbeing seems appropriate, reports of actual experience with the individual programs and policies suggest that there are still many unresolved issues. For example, Alan Fournier, a federal employee diagnosed with mental disabilities who

¹⁷⁹ Public Service Human Resources Management Agency of Canada, *2002 Public Service Employee Survey, Organizational Report*, <http://www.hrma-agrh.gc.ca/survey-sondage/2002/results-resultats/00/result-e.htm>.

¹⁸⁰ National Joint Council, *2004 Annual Report of the Disability Insurance Plan Board of Management*, <http://www.njc-cnm.gc.ca/auxFile.php?AuxFileID=260>.

¹⁸¹ Treasury Board Secretariat, *Policy on the Duty to Accommodate Persons with Disabilities in the Federal Public Service*, 2002, http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/TB_852/ppaed_e.asp.

¹⁸² Treasury Board Secretariat, *Creating a Welcoming Workplace for Employees with Disabilities*, http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/TB_852/cwwed1_e.asp#Definition.

submitted a brief to the Committee, indicated that “there have been those in the Public Service who have been very helpful and supportive. However, they are in the minority.” He told the Committee that he was:

*... not pointing at any one individual or organization with [in] the public service. Rather, the problem seems to [be] more systemic in nature from a culture that talks the talk but will often not walk the walk on disabilities such as mine.*¹⁸³

Mr. Fournier also referred to the limited coverage for professional services provided by the Public Service Health Care Plan.

*An overwhelming number of those of us seeking the services of therapists rely on professionals not covered by provincial health plans. Therefore we are limited to the \$1000.00 annual coverage of the public service health care plan. Most addiction therapists and psychologists charge at least \$100.00 a session. In my case I require a number of professionals including an Addiction Therapist and a Psychologist who is a Learning Disability Specialist. At their rates, I am limited to eight visits annually. Effective therapy, especially at the early stages of addiction is required on a weekly basis. I should be seeing my addiction therapist bi-weekly. I also require a substantial number of expensive prescriptions. Even at eighty percent coverage I often find myself in financial difficulties meeting the difference. The requirement to pay medical expenses up front means a substantial portion of my income is always in transit waiting for claims to be processed.*¹⁸⁴

Dorothy Cotton, Co-chair/Psychologist, Canadian National Committee for Police/Mental Health Liaison, pointed to the fact that, in practice, the way the federal government, as an employer, treats its psychologists actually contributes to the overall stigma of mental illness:

The way the federal government, as an employer, treats its psychologists actually contributes to the overall stigma of mental illness.

*The Federal Government is a bad employer in this way. You know, wages are easily 30% below market value for psychologists in the Federal Government scales, it is humiliating, and which contributes to the whole stigma issue.*¹⁸⁵

Diana Capponi, consumer/advocate, was pleased that the federal Minister of Health had appointed the Hon. Michael Wilson and Bill Wilkerson to review issues relating to mental health and the workplace within the federal government. However, she cautioned that:

Being Canada's largest employer, I would suggest there are changes to be made. I would hope that these changes would include the targeted recruitment of people

¹⁸³ Brief submitted 30 March 2005.

¹⁸⁴ Brief submitted 30 March 2005.

¹⁸⁵ 16 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/06eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

*with mental health or addiction issues, and that the Federal Government will go well beyond the efforts of our banking sector, in that all positions, all levels or classifications of employees be filled by people with mental health and addiction issues. This would demonstrate to the Canadian public and your employees that you are “Walking the talk.”*¹⁸⁶

13.7.4 Committee Commentary

The Committee notes the initiatives taken by the former federal Minister of Health, the Hon. Ujjal Dosanjh, to focus attention on mental health issues in the public service. One example was the February 2005 appointment of the Hon. Michael Wilson, now Ambassador to the United States, as special ministerial advisor on mental health in the federal government workplace.¹⁸⁷

In Chapter 8 on general workplace issues, the Committee drew heavily on the work of the Global Business and Economic Roundtable on Addiction and Mental Illness (the Roundtable), that was founded in 1998 to serve as an “instrument of information analysis and ideas concerning the linkage between business, the economy, mental health and work.”¹⁸⁸ Among employers, the Roundtable has raised the level of awareness of mental health issues and has facilitated the sharing of best practices. Indeed, effective solutions and approaches to promoting better workplace wellbeing have already been developed by the private sector.

The federal government, as an employer, could benefit from the establishment of wider community relationships in developing better practices for its own workplaces, in particular, the elimination of the stigma associated with mental illness.

The federal government, as an employer, could benefit from the establishment of wider community relationships in developing better practices for its own workplaces, in particular, the elimination of the stigma associated with mental illness.

The Committee therefore recommends:

84 That the federal government draw upon the model established by the Global Business and Economic Roundtable on Addiction and Mental Illness in coordinating interdepartmental mental health policies, programs and activities for employees.

¹⁸⁶ 15 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/05eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁸⁷ Public Health Agency of Canada, *News Release*, “Michael Wilson to serve as Special Ministerial Advisor on Mental Health,” 4 February 2005.

¹⁸⁸ Global Business and Economic Roundtable on Addiction and Mental Health, website, http://www.mentalhealthroundtable.ca/about_us.html.

That the federal government, as an employer, form a partnership with other sectors and jurisdictions, including the Global Business and Economic Roundtable on Addiction and Mental Health, to stimulate and facilitate the exchange of best practices in the support of workplace wellbeing and better employee mental health.

That, as it develops strategies to support mental health in its workforce, the federal government place a specific emphasis on measures that will reduce and eventually eliminate the stigma attached to mental illness.

The Committee believes it essential to evaluate programs regularly to see whether they are meeting their objectives and satisfying real needs. To determine the efficacy of the programs and policies currently in place that are designed to assist government employees facing mental health problems, the federal government must do more than simply list the programs and policies.

Accordingly, the Committee recommends:

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| 85 | <p>That the Public Service Human Resources Management Agency conduct annual evaluations of the federal government's provision of policies, programs, and activities designed to support mental health in the public service;</p> <p>That these evaluations be based on clear performance indicators that include the use of surveys to assess employee satisfaction;</p> <p>That the evaluations be used as a basis for adjustments to policies, programs, and activities in order to better suit them to the needs of employees;</p> <p>That results of these evaluations, and the adjustments that were made based upon them, be reported to Parliament on an annual basis starting in 2008.</p> |
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13.8 TOWARD A FEDERAL GOVERNMENT STRATEGY FOR FEDERAL CLIENTS

Federal clients, like all Canadians, need a range of programs and services to sustain or attain positive mental health. As we have seen throughout this chapter, each federal client group confronts particular challenges and each requires solutions specifically targeted to their needs. Thus, for example, attention to fundamental determinants of health such as housing and community supports are a crucial factor among veterans and First Nations and Inuit populations. For federal public service employees, on the other hand, workplace conditions and accommodations for people living with a mental disorder are of prime importance.

It is also important to reiterate that the federal government is responsible for these different client groups for varying periods of time. Some, like First Nations and Inuit, are clients for life. Veterans generally access mental health services at a later stage in their lives. Refugees, as they gain access to provincial services, may be able to stop relying on the federal government within a few months of arrival in Canada, while federal offenders remain in the care of the federal government until their release. Others, like the RCMP, Canadian Forces members and public servants, are the responsibility of the federal government for as long as they are employed within the federal jurisdiction.

The Committee cannot understand why the federal government has never developed a clear and consistent approach to address the concerns of the client groups for which it is responsible.

The Committee believes it necessary to develop such a comprehensive strategy aimed at improving the health status of all federal client groups while acknowledging also the distinct needs of each group.

The Committee recognizes that this wide range of situations poses a challenge to the federal government in ensuring that the necessary programs and services for mental health, mental illness and addiction are available to all clients. Nevertheless, the Committee cannot understand why the federal government has never developed a clear and consistent approach to address the concerns of the client groups for which it is responsible. The Committee believes it necessary to develop such a comprehensive strategy aimed at improving the health status of all federal client groups while acknowledging also the distinct needs of each group.

The Committee therefore recommends:

86	<p>That the federal government develop a strategy for mental health that is inclusive of all federal client groups and that takes into account each group’s particular needs.</p> <p>That the strategy set goals, including a timetable for implementation and for subsequent evaluation.</p> <p>That the strategy have as its objective making the federal government a model employer as well as model provider with respect to its various clients.</p>
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13.8.1 Incorporating a Determinants of Health Approach

Historically, the federal government has been a leader in the development of the concepts of population health, starting with the landmark Lalonde report. The Committee believes that the government has both the opportunity and obligation to apply these concepts to its own clientele.

The Committee believes that the government has both the opportunity and obligation to apply population health concepts to its own clientele.

In 2004, the federal government reported that it was the fifth-largest provider of health services to Canadians, serving approximately 950,000 people at a cost of \$3.4 billion

annually.¹⁸⁹ The Committee believes that the federal government's commitment to mental health must include a focus on the determinants of health that extends beyond health services as such, given the many factors relevant to the various client groups. These encompass a range of determinants including: adequate housing, access to income, the presence of social support networks, as well as educational opportunities and the availability of employment.

Given its substantial responsibilities for the provision of mental health service, the federal government must lead by example, including by focusing on the promotion of mental health and the prevention of mental illness and addictions.

Given its substantial responsibilities for the provision of mental health service, the federal government must lead by example.

Through interdepartmental collaboration and sustained work with its client groups, the federal government could set a standard for the whole country in the development and application of population health models.

The Committee therefore recommends:

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| 87 | <p>That the mental health strategy to be developed by the federal government incorporate a population health approach to the determinants of mental health, and that it specifically address the economic, educational, occupational and social factors that have an impact on the mental health of all federal clients;</p> <p>That the federal government report to Parliament in 2008 on what precisely it is doing to implement a population health approach for federal clients.</p> |
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13.8.2 Initiating Anti-Stigma Activities

In Chapter 16, the Committee recommends that the Canadian Mental Health Commission undertake a sustained, ten-year campaign to combat the stigma associated with mental illness. The presence of a federal representative on the Board of the Mental Health Commission will provide a federal input into the Commission's pan-Canadian anti-stigma campaign. The Committee believes, however, that the federal government also has a responsibility to lead directly in reducing the stigma associated with mental health among its specific client groups.

The Committee recommends:

¹⁸⁹ Health Canada, *Healthy Canadian: A Federal Report on Comparable Health Indicators*, 2004, http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2002-fed-comp-indicat/2002-health-sante4_e.html.

88 **That the federal government immediately develop and implement an anti-stigma campaign for all federal client groups.**

13.8.3 Providing an Avenue of Redress

As stated previously in this chapter, over several decades various federal departments have established some form of external independent, impartial oversight body for a broad range of matters affecting federal clients. Many of these entities are mandated to include reviews of mental health concerns. For example, the Correctional Investigator and the RCMP External Review

The Committee has recommended that the responsible federal departments establish similar forums for other federal client groups like veterans, First Nations and Inuit, immigrants and refugees that currently have no recourse to such a person or entity.

Committee are mandated through legislation to investigate and assess mental health issues, as well as other issues of concern relevant to their respective groups; they report to the relevant federal ministers with recommendations for action. Others like the Canadian Forces Ombudsman and the special advisor on mental health in the federal government workplace have no legislated mandate.

The Committee has recommended that the responsible federal departments establish similar forums for other federal client groups like veterans, First Nations and Inuit, immigrants and refugees that currently have no recourse to such a person or entity.

As part of the overall federal strategy, the Committee believes it is important to link oversight positions within individual departments to each other to provide a coordinated federal ombudsman role for specific issues relating to mental health. It envisions an entity that can investigate and resolve individual complaints, review and make recommendations, identify systemic areas of concern, and follow-up for clients from all federal client groups.

The Committee recommends:

89 **That the federal government establish a central coordinating mechanism for the development and delivery of mental health policies, programs, and activities across its departments and agencies;**

That this federal body work with the Correctional Investigator, the Canadian Forces Ombudsman, and the RCMP External Review Committee and other similar entities to be established by departments to ensure that the needs of individual client groups are being addressed;

That this federal body coordinate and monitor the work of these individual entities in investigating and getting responses to concerns about mental health services for each federal client group;

That this federal body provide an annual report to Parliament.

13.8.4 Assessing Federal Insurance for Mental Health

The conditions established under the *Canada Health Act (CHA)* that must be met by provincial health-care insurance plans to receive federal cash transfers expressly exclude some federal client groups. Under “insured health services,” the *CHA* excludes “any health services that a person is entitled to and eligible for under any other Act of Parliament.” It also excludes any “hospital or institution primarily for the mentally disordered.” More specifically, it defines “insured persons” for whom health services would be provided under provincial health care plans to mean a resident of the province, other than:

The federal government is completely responsible for the provision of health programs and services to three client groups — Canadian Forces, RCMP and federal offenders. Others — First Nations and Inuit, veterans, immigrants and refugees and federal employees — are under federal responsibility to significant but varying degrees. The federal government believes that provincial governments should shoulder the broad responsibility for the health of these latter groups of clients just as they do for the general Canadian population.

- “(a) a member of the Canadian Forces,
- (b) a member of the Royal Canadian Mounted Police who is appointed to a rank therein,
- (c) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*.”¹⁹⁰

Thus, the federal government is completely responsible for the provision of health programs and services to three client groups — Canadian Forces, RCMP and federal offenders. Others — First Nations and Inuit, veterans, immigrants and refugees and federal employees — are under federal responsibility to significant but varying degrees.

Each client group has mental health needs that are not covered under provincial insurance plans. To meet these uninsured needs, the federal government has developed a separate approach for each client group.

The federal government believes that provincial governments should shoulder the broad responsibility for the health of these latter groups of clients just as they do for the general Canadian population. As Ian Potter explained with reference to First Nations and Inuit clients:

¹⁹⁰ *Canada Health Act*, Chapter C-6, Section 2 — Interpretation, <http://laws.justice.gc.ca/en/C-6/17077.html#rid-17084>.

*... those services that are covered by the Canada Health Act, what we call insured services, are provided by the province. If the federal government is arranging for physician services or hospital services, we charge the province back for those services.*¹⁹¹

However, each client group has mental health needs that are not covered under provincial insurance plans. To meet these uninsured needs, the federal government has developed a separate approach for each client group. The Canadian Forces, RCMP and Corrections Canada cover non-insured health care and mental health treatment as a matter of operational necessity; First Nations and Inuit have access to the Non-Insured Health Benefits Program; veterans have the Health Benefits Program; refugees have the Interim Federal Health Program; and public servants have the Public Service Health Care Plan. In addition, there are a variety of disability insurance plans.

George Lucki, Chair, Alberta Alliance on Mental Illness and Mental Health, noted that federal efforts to cover the additional needs of its clients were characterized by a lack of coordination with the provinces:

The federal government is a leading purchaser of uninsured benefits that provide those who work for the federal government or those whose health care is a federal responsibility with mental health care that is not available to the people of Canada at large.

*These services themselves are often not particularly well coordinated with other health services that are delivered by provincial authorities. We believe that these programs should be comprehensively reviewed to ensure that they reflect best practices, address the mental health needs of those they serve.*¹⁹²

The Committee was surprised to learn not only about the wide range of insurance plans that exist to cover federal clients, but also about the lack of coherent reporting on and assessment of these plans. Health Canada's Non-Insured Health Benefits Program for First Nations and Inuit was the only plan that provided a comprehensive annual report to Parliament. The Committee heard occasional references to other plans but received no formal descriptions or reports.

The Committee was surprised to learn not only about the wide range of insurance plans that exist to cover federal clients, but also about the lack of coherent reporting on and assessment of these plans.

The Committee therefore recommends:

¹⁹¹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁹² 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

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| 90 | <p>That the federal government immediately undertake an assessment of all of its insurance plans for all federal clients to determine their applicability and effectiveness;</p> <p>That this assessment include a comparative evaluation of benefits, of coverage for specific mental health, mental illness and addiction needs, of administrative costs, and of results achieved under the various insurance plans;</p> <p>That this review of insurance plans be reported to Parliament in 2008.</p> |
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13.8.5 Coordinating and Reporting to Parliament

In 2005, the Minister of Health initiated an interdepartmental task force to identify better ways to integrate services and approaches between federal departments with a stake in mental health issues. This task force includes representation from 20 departments and agencies and is jointly led by Health Canada and the Public Health Agency of Canada. Its mandate is to study federal activities and improve coherence in the areas of mental health promotion and prevention, the provision of services, and policy development. The Committee believes that this is an important first step in the right direction, but sees the need for the federal government to go much further in its efforts to coordinate its various programs and services.

Despite the presence of policies, programs, and activities in numerous departments and agencies of the federal government that address the mental health needs of various client groups, the Committee found no central source with overall knowledge of federal activities in this area. There is no forum in which the exchange of solutions and best practices can occur, and no single source of information on the availability of programs, their cost, or their performance.

Despite the presence of policies, programs, and activities in numerous departments and agencies of the federal government that address the mental health needs of various client groups, the Committee found no central source with overall knowledge of federal activities in this area. There is no forum in which the exchange of solutions and best practices can occur, and no single source of information on the availability of programs, their cost, or their performance. Importantly, no one has a complete picture of either the state of mental health of federal clients or of the full range of services available to support them. This lack of coordination can only lead to overlap and wasteful duplication of effort.

The federal government does not provide comprehensive and coordinated annual reports to Parliament on any aspect of its provision of health and health care services.

The Committee also believes it essential for the federal government to provide regular reports to Parliament on its mental health programs and services.

The Committee also believes it essential for the federal government to provide regular reports to Parliament on its mental health programs and services. At present,

Parliamentarians are expected to make decisions about mental health, mental illness and addiction for federal clients without having access to full information. For example, when the Auditor General of Canada reported in 2004 on federal drug benefit plans, she noted that, while federal organizations have highly useful and current data about drug use, that information is not systematically assessed or disseminated to facilitate meeting client health needs.¹⁹³

While departments provide some limited details in their plans and priorities or performance reports, no full reporting on federal health programs is made to Parliament. The Committee notes that, under the *Canada Health Act*, each provincial and territorial government is required to submit a report annually on physician, hospital and other relevant health services. In the meantime, the federal government does not provide comprehensive and coordinated annual reports to Parliament on any aspect of its provision of health and health care services.

Under the *Canada Health Act*, each provincial and territorial government is required to submit a report annually on physician, hospital and other relevant health services.

The Committee has already called for reports from individual departments with significant responsibility for the mental health of particular groups of Canadians. It wants a coordinated approach to this reporting to provide Parliament with the comprehensive information it needs to make legislative and budgetary decisions affecting these specific clients.

The Committee therefore recommends:

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

¹⁹³ Auditor General of Canada, *Management of Federal Drug Benefit Programs*, Chapter 4, November 2004, [http://www.oag-bvg.gc.ca/domino/reports.nsf/html/20041104ce.html/\\$file/20041104ce.pdf](http://www.oag-bvg.gc.ca/domino/reports.nsf/html/20041104ce.html/$file/20041104ce.pdf).

14.1 INTRODUCTION

... for Aboriginal people the health continuum is about wellness and not illness. Aboriginal mental health is relational because strength and security are derived from family and community. Apart from sharing healing traditions, Aboriginal communities are bound by a concept of wellness wherein the mind, body, spirit and soul are interconnected. —Debbie Dedam-Montour¹⁹⁴

For too many Aboriginal peoples, the wellness continuum has been seriously disrupted. Individuals and communities wage a daily battle with adverse conditions in their physical, social and emotional environments. For large numbers, the outcomes are chronic unemployment, violence, addictions and suicide. The Committee can reach only one conclusion — Canada’s record of treatment of its Aboriginal citizens is a national disgrace.

The Committee can reach only one conclusion — Canada’s record of treatment of its Aboriginal citizens is a national disgrace.

Despite multiple reports and substantial allocations of human and financial resources, the overall mental health of Aboriginal peoples continues to be at serious risk. Their mental health is located at the extreme negative end of the continuum.

It is highly misleading, moreover, to speak of Aboriginal peoples as a single homogeneous unit. The *Constitution Act, 1982* recognized three groups of Aboriginal peoples — defined as the “Indian, Inuit and Métis peoples of Canada.”¹⁹⁵ Witnesses, acknowledging the diversity that exists between and within each of these groups, emphasized:

To have a fundamental impact on the mental health of Aboriginal peoples, a number of changes or actions must take place. Policies, programs and procedures developed by the government need to be respectful and inclusive of all First Nations, Métis and Inuit concepts of health and healing. —Bernice Downey¹⁹⁶

The Committee struggled with the knowledge that, despite multiple reports and substantial allocations of human and financial resources, the overall mental health of Aboriginal peoples continues to be at serious risk. Taking the rates of suicide and of addiction as measures, their mental health is located at the extreme negative end of the continuum. Witnesses expressed frustration over the frequency of governmental consultations and the absence of actions that lead to improved outcomes. In the words of one presenter:

¹⁹⁴ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁹⁵ Throughout the chapter, references to Aboriginal peoples are intended to include individuals who identify themselves as First Nations, status Indians, non-status Indians, Métis, or Inuit.

¹⁹⁶ 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

The reality is that our comments and our suggestions are documented, but it has yet to be proven that they have been implemented. —Lorraine Boucher¹⁹⁷

The Committee acknowledges that it cannot in a single chapter review the long and negative legacy of Canada's Aboriginal peoples. Our intent in this chapter is to give another voice to the individuals who took the time to share their ideas with us. The Committee heard that the same factors that promote wellness for Aboriginal peoples — family and community support, economic opportunities, social and physical security, etc. — are, in their absence, the ones that create the need for healing. We heard also that if Aboriginal peoples could take ownership and control of their personal and community health, much of their present ill-health would be prevented.

14.1.1 A National Aboriginal Advisory Committee

The Committee wants to ensure that ongoing national mechanisms are put in place to provide avenues for obtaining the advice of Aboriginal peoples and translating it into action. In its recommendation to create a Canadian Mental Health Commission (see Chapter 16), the Committee incorporated three specific measures designed to guarantee that this happens. First, one of the governmental nominees will be a representative of the territorial governments, and will therefore be in a position to speak to the specific concerns of Aboriginal people living in the north. Second, the Commission report specifies that the non-governmental members of the governing Board of the Commission must include people who have experience of, and understand the issues confronting, people of Aboriginal origin. Third, of the two advisory committees that must be put in place by the Commission, one must be an Aboriginal Advisory Committee.

The Committee wants to ensure that ongoing national mechanisms are put in place to provide avenues for obtaining the advice of Aboriginal peoples and translating it into action.

Within the structure of the Mental Health Commission, the Aboriginal Advisory Committee will have a status equivalent with and parallel to the status of the advisory committee representing the provincial and territorial governments.

The Committee recognizes that a report such as this one that is focused on mental health, mental illness and addiction cannot address all the broad constitutional, policy and governance issues that have a real impact on the health and well-being of Aboriginal peoples. However, the Committee strongly believes that its recommendations for improving the mental health of Aboriginal peoples may help open the door to broader initiatives.

In this regard, it should be noted that, besides the Aboriginal Advisory Committee, the Mental Health Commission is required to create only one other advisory committee which will be composed of representatives of all the provincial and territorial governments. Thus, within the structure of the Mental Health Commission, the Aboriginal Advisory Committee will have a status equivalent with and parallel to the status of the advisory committee representing the provincial and territorial governments.

¹⁹⁷ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

For the Committee, this Aboriginal Advisory Committee is a vital component of a larger (and longer-term) endeavour aimed at significantly improving the mental health and well-being of all Aboriginal peoples. The Committee believes that the Aboriginal Advisory Committee will provide a crucial focal point for furthering the development of a specific strategy for mental health that reflects the distinct approaches needed by all groups of Aboriginal peoples. As the following sections emphasize, this strategy must be based on the recurring calls by Aboriginal peoples for community authority and control, cultural accommodation, and equity of access with respect to mental health programs and services.

The Committee also believes that the recommendations it makes in this report for ensuring that Aboriginal peoples themselves are fully involved in the design and delivery of improved mental health services and supports are entirely consistent with the community-based orientation for mental health that the Committee is advocating for the general population. It therefore hopes that the Aboriginal Advisory Committee will be able to promote a fruitful two-way dialogue within the Mental Health Commission that will allow non-Aboriginal Canadians to learn from the experience and traditions of Aboriginal Canadians in promoting mental health and well-being.

The Committee thus emphasizes the recommendation made in Chapter 16:

92	That the Canadian Mental Health Commission (see Chapter 16) establish an Aboriginal Advisory Committee comprised of representatives of Aboriginal communities, whose membership shall be determined by the Commission in consultation with Aboriginal organizations, and shall provide representation from First Nations, Inuit and Métis and broadly reflect the geographic distribution of Aboriginal communities across the country.
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14.2 WELLNESS AS THE GOAL

Witnesses representative of all Aboriginal peoples emphasized that the focus must be changed from mental illness to mental wellness. They called for a holistic and comprehensive approach addressing all determinants of health.

Witnesses representative of all Aboriginal peoples emphasized that the focus must be changed from mental illness to mental wellness. They called for a holistic and comprehensive approach addressing all determinants of health.

Valerie Gideon, Director of Health and Social Secretariat, Assembly of First Nations, noted a call for a comprehensive and holistic First Nations wellness strategy:

Certainly, that strategy would have mental health and suicide prevention as a key point of focus. It would look at a holistic approach for mechanisms that would enable communities to have the flexibility to allocate resources toward priorities and make linkages with some of the health determinants that are

*fundamental, such as education, housing, and social and environmental issues.*¹⁹⁸

The Inuit also seek an approach reflective of their particular circumstances. According to Onalee Randell, Director of Health, Inuit Tapiriit Kanatami, Inuit need:

*a...continuum of services that incorporates traditional knowledge and practices that are based in their home community or, at a minimum, their home region; ...that provides supports for individuals and families; and services that breach the barriers and [address] both the medical and non-medical determinants of mental wellness, including economic and environmental matters, and housing and education.*¹⁹⁹

Although few Métis organizations participated directly in Committee proceedings, Bernice Downey, Executive Director, National Aboriginal Health Organization, presented the perspective of the Métis health unit. She emphasized that the development of a comprehensive and inclusive plan for mental health, mental illness and addiction:

*...hinges on the awareness of the governments to acknowledge and respect not only the jurisdictional rights of Metis, but also the concept of health and wellness from a Metis perspective.*²⁰⁰

14.2.1 Mental Health Rather Than Mental Illness

Talking only about mental illness constitutes, for most witnesses, a negative, stigmatizing approach that discourages people from raising particular mental health issues. Some like Arnold Devlin, Dilico Ojibway Child and Family Services, argued that:

Witnesses spoke of the need to adopt a holistic approach to address an individual's spiritual, emotional, mental and physical needs when placed against the external social, cultural, economic and political reality experienced by that individual.

*It is important to differentiate between mental problems and mental illness. There is no reason to expect, and I see no evidence that mental illness is any greater within the native community than it is in the general population. The fact that we have more mental problems is true. That is what we are referring to and looking at. There is a highly significant difference between the two.*²⁰¹

He emphasized that, for many Aboriginal peoples, the outward manifestations of their situation should be seen “as mental distress versus mental illness. The level of mental

¹⁹⁸ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

¹⁹⁹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁰⁰ 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁰¹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

distress can be a specific episode that lasts a certain length of time but I would not classify it as a mental illness.”²⁰²

The Committee heard that Aboriginal peoples are not more predisposed than anybody else to particular mental illnesses but that individuals can manifest profound inability to manage in Canadian society, a powerlessness too often expressed as depression, suicide and addiction. Elsie Bastien, Aboriginal Liaison Coordinator, Alberta Mental Health Board, argued that:

*Mental health is a concern for Aboriginal communities not because Aboriginal people have higher rates of severe mental illness such as schizophrenia, but because so many show signs of low level yet debilitating disturbances. The indicators of this are the high rates of alcohol and drug abuse, suicide, accidents, violence, as well as educational failure, unemployment and incarceration.*²⁰³

To prevent or to address these negative outcomes, witnesses spoke of the need to adopt a holistic approach to address an individual’s spiritual, emotional, mental and physical needs when placed against the external social, cultural, economic and political reality experienced by that individual. As expressed by Sheila Levy, President, Nunavut Kamatsiaqtut Help Line:

*Poverty, crime, violence, addictions, all categories of abuse, overcrowded housing, alienation, abandonment and suicide are all connected to mental and physical well-being. That interconnectivity of mental health issues is often forgotten.*²⁰⁴

14.3 WELLNESS THROUGH HEALING

Achieving the emotional wellness desired by and for the individuals, families, and communities of all Aboriginal peoples requires healing. While recognizing the continuing impact of past injustices, witnesses expressed a strong desire to move forward using healing practices appropriate to their traditional cultures.

Bernice Downey talked about the Métis perspective on healing that:

*...includes the provision of services in their Aboriginal language and the inclusion of traditional knowledge and healing practices.*²⁰⁵

²⁰² 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁰³ 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁰⁴ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁰⁵ 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Jennifer Dickson, Executive Director, Pauktutit Inuit Women's Association, called for:

*...a healing centre in each of Canada's remote Arctic communities. Well-trained mental health resource people must be available. These centres might provide places where Inuit elders, adults, youth and organizations could truly listen to each other and involve each other in meaningful interventions and traditional healing.*²⁰⁶

Bill Mussell, Chair, Native Mental Health Association, insisted that, if First Nations people had the chance to understand their past through healing processes, they would adopt healthier ways of coping:

Witnesses expressed a strong desire to move forward using healing practices appropriate to their traditional cultures.

*When you think about grieving, healing, and the effects of trauma, there is a process of helping people to get in touch with what happened so they can continue to grow and develop. They must get in touch with their experiences. This process can be successful when performed with people who care about them that can provide them with the safety that is necessary to begin to get in touch with the dynamics of their life.*²⁰⁷

14.3.1 The Need for Healing

In addition to socio-economic and situational factors, the Royal Commission on Aboriginal Peoples identified culture stress brought about by the loss of land and control over living conditions, suppression of belief systems and spirituality, weakening of social and political institutions, and racial discrimination as destructive forces that continue to damage the confidence and overall health of Aboriginal peoples.²⁰⁸

Of the almost 1 million Aboriginal people currently in Canada, over one-third have been affected either directly by residential school experiences or indirectly as family or community members linked to survivors.

To understand fully the need for healing, Tarry Hewitt, Project Coordinator, Aboriginal Survivors for Healing, reminded Committee members that:

...the historical context is critical. In revisiting the impact of colonization and, in particular, the legacy of the residential school system, it may appear that we are going over old ground already dealt with in the previous reports produced by

²⁰⁶ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁰⁷ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁰⁸ Royal Commission on Aboriginal Peoples. (2005) Choosing Life: Special Report on Suicide Among Aboriginal Peoples.

*this committee. However, it is important to connect the dots to examine how we got here from there in order to understand how to move ahead.*²⁰⁹

According to Gail Valaskakis, Director of Research, Aboriginal Healing Foundation, the trauma for Aboriginal people exposed to residential schools will take several generations to remedy:

*It has to do with the loss that people who attended residential schools suffered in regard to language, to culture, to family, to nation, and with the impact that had on Aboriginal communities with respect to a cycle of abuse over a long period of time; in regard to the lack of parenting skills that related to their experience in residential schools and historical trauma — something we have learned a great deal about lately — with regard to the grief and loss that Aboriginal people have felt over many years of displacement, loss of culture, loss of language and death in their own communities.*²¹⁰

She estimated that “it takes a community an average of 10 years to reach out, to dismantle denial, to create safety and to engage participants in the therapeutic healing process.”²¹¹ Of the almost 1 million Aboriginal people currently in Canada, over one-third have been affected either directly by residential school experiences or indirectly as family or community members linked to survivors.

14.4 STRATEGY FOR WELLNESS AND HEALING

So what is the way to build and to restore wellness for all Aboriginal peoples? Out of the many individual submissions and interventions, one message emerged clearly. For First Nations, Inuit and Métis, the pressing need is for a wellness and healing strategy with a clear action plan that can and will be implemented. People want action on overall mental health that will produce positive results for their communities.

The pressing need is for a wellness and healing strategy with a clear action plan that can and will be implemented.

The strategy must be inclusive of all groups — Indian (status and non-status), Métis and Inuit — from all regions of Canada.

In 2001, the North American Indian population was the largest, at 62%, of the total self-identified Aboriginal population of Canada. Of those North American Indian individuals, about 505,000 were registered Indians with legal status and 104,000 were not registered and lacked legal status. Métis represented about 30% of self-identified Aboriginal peoples, about

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

²¹⁰ 21 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/23evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²¹¹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

292,000 individuals in total. Inuit represented about 5% of the self-identified Aboriginal peoples, enumerated at about 45,000.²¹²

The multiplicity of individuals who identify themselves as Aboriginal people makes it difficult to generalize about overall mental health status and needs. As well, witnesses emphasized the value of approaches designed to meet the specific needs of each particular group:

Just as we now know that the mainstream approaches do not work, are not totally effective, we know that a cookie-cutter application to the three constitutionally recognized groups is not the answer either. It must be specific to the Nations. —Bernice Donney²¹³

And what are some key components of such a compilation of strategies? Witnesses stressed that any approach must be focused on the broad determinants of health and involve participation and cooperation across the economic, social, cultural and health sectors.

Any approach must be focused on the broad determinants of health and involve participation and cooperation across the economic, social, cultural and health sectors.

A comprehensive strategy must include changes to the education system and ways to create economic development opportunities; is not just a look at mental health and family violence and suicide. They are all interrelated — there is interconnectedness. —Debbie Dedam-Montour²¹⁴

Economic opportunities, adequate and effective housing, improved education, gender equity, actions to protect the environment and attention to justice issues are some of the issues that cry for a strong, holistic approach. —Jennifer Dickson²¹⁵

Virtually all witnesses saw the current jurisdictional quagmire as the primary barrier to progress toward wellness and positive mental health. While all groups of Aboriginal peoples (whether First Nations, Métis or Inuit) face disadvantages, each has been forced, through legislative and administrative channelling, into a different relationship with the federal government and hence into different program and service delivery situations with the

²¹² The information is based on data provided by Statistics Canada for the health sectoral table of the Canada-Aboriginal Roundtable, November 2004. It includes four documents: A profile of Canada's North American Indian population with Legal Indian Status; A profile of Canada's North American Indian population without Legal Indian Status; A profile of Canada's Métis population; The Inuit population in Canada. http://www.aboriginalroundtable.ca/sect/hlth/index_e.html.

²¹³ 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²¹⁴ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²¹⁵ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

provincial and territorial governments. Frustration led Donna Lyon, Director, National Aboriginal Health Organization, to call on the federal government to acknowledge that:

*...health programs to all three Aboriginal peoples is a federal, constitutional or treaty obligation as the case may be...*²¹⁶

Witnesses were clear about the necessary building blocks of a successful strategy. They emphasized the need to focus on the determinants of health and on clarification of the jurisdictional and departmental confusion currently surrounding responsibility for the overall health status of Aboriginal peoples. They insisted that, if such a strategy is implemented, many of the negative mental health problems currently facing individuals and communities will be prevented.

The Committee strongly supports the development of a strategy oriented to promotion of wellness, to restoration of positive mental health and to prevention of worsening mental health outcomes for Aboriginal peoples. The strategy must be capable of measurably improving the aggregate health status of all Aboriginal peoples and take into account the distinct needs of First Nations, Inuit and Métis regardless of where they live. The strategy must focus on recognized partnerships and meaningful collaboration across social, economic, health and other sectors. The overall goal is to identify flexible, multi-dimensional solutions for the complex problems facing Aboriginal peoples through genuine community participation and shared power to implement change.

Virtually all witnesses saw the current jurisdictional quagmire as the primary barrier to progress toward wellness and positive mental health.

The Committee strongly supports the development of a strategy oriented to promotion of wellness, to restoration of positive mental health and to prevention of worsening mental health outcomes for Aboriginal peoples.

The strategy must focus on recognized partnerships and meaningful collaboration.

In 2003, the First Ministers directed their Health Ministers to consult with Aboriginal peoples on the development of an Aboriginal Health Reporting Framework.²¹⁷ Through the use of indicators permitting comparisons between Aboriginal and non-Aboriginal Canadians, the report is to provide information on the progress achieved and key outcomes. It is intended also to inform Canadians on current programs and expenditures, and provide a baseline against which new investments, service levels and outcomes could be tracked over time. This “report card” information is essential to the success of any wellness and healing strategy.

The strategy must include specifics about who will control its implementation, how to measure wellness, what goals can be established, when actions are to be implemented, and by what criteria the outcomes will be judged. It is essential to include a specific time frame

²¹⁶ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²¹⁷ Health Canada. (September 2004) Information: The 2003 Accord on Health Care Renewal. http://www.hc-sc.gc.ca/hcs-sss/medi-assur/fptcollab/2004-fmm-rpm/fs-if_01_e.html.

for implementing actions and evaluating outcomes, as well as a sustained and sufficient funding mechanism.

The Committee recommends:

93 **That, as a priority, the Canadian Mental Health Commission (see Chapter 16), with the full involvement of its Aboriginal advisory committee, develop a strategy for mental health wellness and healing among Aboriginal peoples.**

That the strategy set goals, including a timetable for implementation, and recommend ways to evaluate outcomes.

That the strategy adopt distinct approaches for First Nations, Inuit and Métis.

14.5 ACTION ON HEALTH DETERMINANTS FOR EACH GROUP

Witnesses emphasized that a successful strategy will rely on full recognition of the range of conditions or health determinants that contribute to the poor health status of Aboriginal peoples. They illustrated how key factors in the broader environment — income and social status, social support networks, education, employment, social and physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture — are relevant to good mental health. But most importantly, they talked about how, if the positive effect of each of these determinants can be made available to Aboriginal people, many negative mental as well as physical health outcomes could be prevented.

Key factors in the broader environment — income and social status, social support networks, education, employment, social and physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture — are relevant to good mental health.

14.5.1 Culture- and Group-Specific Approaches

As noted earlier, Aboriginal peoples are diverse. Even among those who identified themselves as North American Indians (almost 65%), Métis (30%) or Inuit (5%), there are many different cultural practices, relationships, languages, and social, economic, and geographical situations within Canada's jurisdictional boundaries.

Witnesses envisioned traditional healing, language and culture as critical in overcoming negative attitudes and behaviours.

For First Nations, the 2001 Census indicated that over half (52%) of North American Indians with legal status lived on reserves. Witnesses emphasized how the very existence of reserves affected the mental health of North American Indian populations, a fact frequently exacerbated by their remote location.

As James Morris, Executive Director, Nodin Counselling Services in northern Ontario, commented:

*I do not need to talk about the environment in which these people live; they live in debilitating poverty in remote communities. It is the same story in any remote area where people are poor. The environment is the same in all First Nations communities. I never think of a reserve as the normal environment for First Nations people.*²¹⁸

For Inuit, geographical location points to certain needs with respect to program and service delivery. Five of the largest Inuit communities (with populations from 1,500 to 3,000) are clustered above or near the 60th parallel in western territories and eastern provinces. The Committee was reminded that it was only within the last 50 years, as the federal government established a significant presence in the Arctic, that Inuit were moved away from seasonal camps and relocated into permanent settlements.

According to Jennifer Dickson:

*During the 1950s, Inuit in seasonal camps and in smaller communities were compelled to resettle at other existing communities when church, health and government officials decided that their social and economic welfare would be improved by living in larger centres. However, this program seriously disrupted the historical and cultural organization of the people and had long-lasting negative consequences for resettled families.*²¹⁹

For the Métis as well, history has determined their current status — particularly the fact that, to date, their relationship with other Canadians has not been governed by treaties or land claims. In 2001, almost one-quarter of all Métis lived in Alberta, and the province is unique in having Métis settlement legislation that delegates to them authority to develop limited bylaws and policies in specific northern areas. However, nearly 70% of the total Métis population across Canada live in cities (outside of specific settlements), together with more than seven in ten (73%) of those North American Indians who do not have legal Indian status.

Witnesses envisioned traditional healing, language and culture as critical in overcoming negative attitudes and behaviours. Tarry Hewitt called for community-based decisions about conventional or traditional healing practices, but noted that:

*...acknowledgment of the efficacy of traditional practices to promote healing is critical to overcoming the habits of dependency and to restoring Aboriginal self-esteem and confidence in their own cultural imperatives.*²²⁰

²¹⁸ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²¹⁹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

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

In a similar vein, Jennifer Dickson supported culturally relevant approaches:

*Unique traditional knowledge and culture is central to Inuit health and well-being. Inuit wisdom and ways must be incorporated into all programs if we are to affect individual and community health positively.*²²¹

14.5.2 Family and Community Supports

Many witnesses emphasized that strong families and communities are essential to achieve overall wellness. They acknowledged the need for individual choices, but stressed how collective social factors exert a major influence on many decisions that Aboriginal peoples make about their lives.

Bernice Downey observed how healthy families make strong communities:

*When you talk about mental health, you look at healthy families. You see they have ways to support themselves, a sense of purpose in their life, and a job that they feel they can make a contribution to. They can undertake their ways of life and not be restricted by restrictions on hunting, as an example, so that they can teach those traditions to their youth and their youth then can go forward. That is what mental health is all about for communities.*²²²

Other witnesses stressed that caring social relationships and supportive networks provide stability for people and help them solve problems and deal with adversity. Individuals lacking a sense of control over their life circumstances have decreased overall well-being. Bill Mussell proposed a concept of “community of care” as one way to protect against potential problems:

I like the notion of “community of care.” Our young people feel that they are homeless people even though they have a house with a roof, walls and so on. They have a house but not a home. Their caregivers are not there, their loved ones are not there, and the people they would like to have care about them are absent.

The better question is this one: What do we need to do with limited resources to contribute to the creation of that community of care?

*I do not think you can buy it, but I certainly think you can do things to contribute to its development.*²²³

The fact that Aboriginal peoples frequently change their place of residence is a concern. It leads to a lack of continuity in social connections as well as the subsequent loss of a sense of

²²¹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²²² 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²²³ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

community. Census data indicated that the on-reserve population was relatively stable, but one-third (33%) of the North American Indian population with legal Indian status in large cities moved every year. As well, 25% of the North American Indian population without legal Indian status and 23% of the Métis population moved each year — twice the mobility of non-Aboriginal people (14%).

14.5.3 Children and Youth

The population of all Aboriginal groups is much younger than the non-Aboriginal population. Inuit have the youngest population, with a median age of only 20.6 years, compared to the non-Aboriginal population's 37.7 years. This means that 40% of Inuit are children under 15 years of age. Of the Métis population, 30% are children under 15 years of age. Of the North American Indian population, 25% of those with legal status and 35% of those without legal status are children under 15 years of age.

The population of all Aboriginal groups is much younger than the non-Aboriginal population.

Setting up youth internships; creating youth employment opportunities; promoting traditional values and teachings; consulting with the Winnipeg Police Service and the RCMP; providing workplace safety education; and focusing throughout on suicide prevention.

Children are particularly affected by social supports, physical environments, family stability and socio-economic status. James Morris shared his experience and observations on the critical importance of adequate support for young people:

I know kids who are hungry. I know kids who are not well clothed. I know kids who have no place to sleep. I went to a place in one community, which consisted of just a little trailer. There were 18 people living in there, with three beds. Everybody had to take turns sleeping. If it was not the kid's turn to sleep that night, he did not go to school the next day. He had to go to bed when everybody else got up.²²⁴

Gloria Laird, Co-Chair, Alberta Mental Health Board, Wisdom Committee, talked about the difficulties of having a large number of Aboriginal children and youth in the social service system in which only a tiny percentage of staff members are Aboriginal. She also suggested that a high percentage of child prostitutes in Alberta are Aboriginal and that they have special needs that are not met by the current system:

For a number of years I have been advocating for a holistic healing centre. That has not been supported. You can talk until you are blue in the face, but there is no change. The young people are saying that they want to go out to the country and they want to have elders present. They say they want to do sweats and they want to clean themselves up. They need something different. They need to get out of the cities.

²²⁴ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

*Who will open a holistic healing centre for those young people who do not have a voice? These children are getting younger and younger, 10 and 11 years old. It is difficult to get out of that lifestyle if you are addicted to drugs such as crystal meth.*²²⁵

There was a strong plea to support young adults as they develop a greater understanding of the world and their place in it. Jason Whitford, Coordinator, Youth Council, Assembly of Manitoba Chiefs, recounted work in a range of important areas: setting up youth internships; creating youth employment opportunities; promoting traditional values and teachings; consulting with the Winnipeg Police Service and the RCMP; providing workplace safety education; and focusing throughout on suicide prevention. The broad goal was to encourage and promote the concept of youth involvement and youth leadership in creating change:

*We are telling the youth if they do not like the way things are there are enough of them that they can take over their communities and re-create them the way they want to see them. Through volunteerism and youth councils, youth organizations, they can start to take ownership of the issues and create opportunities for the other youth around them. They want to see change in their own communities, but there are a lot of youth out there who just do not have the means to express themselves positively.*²²⁶

14.5.4 Socio-Economic Conditions

Witnesses identified a range of socio-economic conditions that have affected their overall health and well-being. In general, amelioration of income inequalities for Aboriginal peoples was linked to improved access to education and to employment that, in turn, affected access to housing, food and other physical and social necessities.

Among the Aboriginal groups, Métis reported the highest median income in 2000 at about \$22,000, a level below that of the non-Aboriginal population by nearly \$8,000. Various factors affect the ability of Aboriginal populations to generate income. For example, education is directly linked to employment opportunities, and the Aboriginal population with incomplete high school is almost twice as high as their non-Aboriginal counterparts. In addition, the youthfulness of the Aboriginal populations means that only about 40% of the Inuit are in the working-age population aged 25 to 65 years.

For too many Aboriginal people, unemployment or underemployment are prevalent factors contributing to poor health.

Factors such as housing and community infrastructure influence psychological well-being. It is particularly significant that Aboriginal households (Indian, Inuit and Métis) are much more likely than non-Aboriginal populations to live in housing below an acceptable standard of adequacy.

²²⁵ 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²²⁶ 31 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Employment provides not only income for necessities like housing and food, but also a sense of identity and purpose, social contacts and opportunities for personal growth. For too many Aboriginal people, unemployment or underemployment are prevalent factors contributing to poor health. As Elsie Bastien testified, not only is employment limited, but, because of social assistance rules, individuals are restricted from participating in other meaningful activities:

Most of our people are unemployed because there is no work. Our unemployment rate is at 85 per cent. The community looked at funding people to take training so that they could then volunteer to work in some of the programs. However, at the beginning of this year, the federal government changed the Welfare Act to reflect, I believe, what the province has, and so many of those people who would have, could have, been doing some of the community work, because we do not have the dollars to pay them, now cannot do that because they have to be looking for gainful employment. They need to demonstrate that they have been seeking gainful employment before they get their welfare cheque at the end of the month.²²⁷

Factors such as housing and community infrastructure influence psychological well-being. It is particularly significant that Aboriginal households (Indian, Inuit and Métis) are much more likely than non-Aboriginal populations to live in housing below an acceptable standard of adequacy (measured by houses in need of major repair) and suitability (measured in terms of crowding of the residents).

Larry Gordon reported that:

In many regions, housing shortages have reached crisis proportions in our area. The mental impact on families so crowded that people must sleep on the floors and in shifts cannot be underestimated in our region. Homeless people drift from relative to relative to find a spot for the night.²²⁸

14.5.5 Gender

To support the mental health of both men and women in Aboriginal communities, changes in practices and priorities are required. Several witnesses stressed the need for greater gender awareness and balance in families and communities as well as in organizational and governmental structures and actions.

Current roles, behaviours, and power relations often place women in a doubly disadvantaged position — as women and as Aboriginal people.

Current roles, behaviours, and power relations often place women in a doubly disadvantaged position — as women and as Aboriginal people. Witnesses noted that the number, quality and effectiveness of services available to Aboriginal women and related supports to their children do not compare to those services provided to Canadians as a whole.

²²⁷ 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²²⁸ 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

But women were also seen as instrumental in effecting real change and successful outcomes for Aboriginal communities. Bill Mussell pointed out that strong women hold the key to their own mental health and that of their families and their communities. Jennifer Dickson stressed that:

*Inuit women are truly the agents of change in Canada's Arctic. If motivated, included, franchised and supported, they can and will contribute substantially to strong, stable, healthy and happy communities.*²²⁹

14.5.6 Recommendation for Action

The Committee listened carefully as witnesses presented evidence related to key health determinants and concurred as to their centrality to mental health, whether of individuals, families, communities, or Aboriginal peoples in general. It agrees with the need for an action plan to focus on multiple determinants of health and on the complex interactions among them. Given the numerous root causes of the mental health problems of Aboriginal peoples, any strategy to address them must be based on clear evidence, both about particular problems and about the dimensions of effective measures to address them.

The Committee recommends:

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

14.6 ACTION ON JURISDICTIONAL RESPONSIBILITIES

The Committee heard frequently that lack of clarity on the jurisdictional responsibility for Aboriginal peoples is one of the major challenges in building a coherent, integrated system to plan and deliver mental health and mental wellness services.

First Nations who are registered Indians on reserve are provided with a number of programs and services relevant to mental health; but when these same people leave the reserve, the

²²⁹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

situation changes. Lorraine Boucher, Director of Health Programs, North Peace Tribal Council, observed that:

*First Nations people are always being thrown back and forth like a political football concerning accessing services. When we are on reserve, we are under the federal government; when we are off reserve, we are under the provincial government.*²³⁰

For the Inuit, the situation is similar. Onalee Randell emphasized that, in the unresolved dispute over jurisdictional responsibilities, it is the people who need services that are suffering:

*There continues to be discussions around responsibility — whether the federal, provincial or territorial governments have responsibility. The outcome is that those discussions are taking precedence over the delivery of services to Inuit communities and preventing those well-needed services from being delivered.*²³¹

Like North American Indians without legal status, Métis face mental health concerns comparable to those of First Nations and Inuit but are continually battling for jurisdictional recognition within the Canadian federation. The federal government does not acknowledge specific responsibilities for Métis or non-status Indians, while the provinces and territories are reluctant to seek legal clarification of the issue. Many Métis simply want clarification about the jurisdiction applying to them, either federal or provincial, so that access to needed services can be made easier.

Lack of clarity on the jurisdictional responsibility for Aboriginal peoples is one of the major challenges in building a coherent, integrated system to plan and deliver mental health and mental wellness services.

*Under the jurisdiction regarding Metis, they need an increase in services provided to them. They also need to resolve the jurisdictional situation so that they are no longer denied access to Aboriginal federal or provincial mental health and related programs. —Donna Lyon*²³²

14.6.1 Defining the Federal Role

Currently, all levels of government are ambivalent about their responsibilities with respect to the health of Aboriginal peoples. The *Constitution Act, 1867*, which provided (in section 91 and 92) a legislative division of powers between the federal Parliament and provincial legislatures, allowed for a division of responsibility for Aboriginal peoples into categories, some of which are accorded status through federal recognition while others are not.

²³⁰ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²³¹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²³² 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

For the federal government, the *Indian Act* has provided a baseline for services to registered status Indians on reserve and to certain Inuit. Following a 2004 commitment to develop an Inuit Secretariat within the Department of Indian and Northern Affairs, the federal government has begun to take a more publicly identified role in its approaches to Inuit-specific issues. Since 1985, except under programs aimed at the general Canadian population, Métis and non-status Indian issues have been dealt with by a federally appointed interlocutor for Métis and non-status Indians rather than by a specific federal department.

Provincial and territorial governments are reluctant to provide Aboriginal-specific funding or services, fearing that they will be perceived as accepting jurisdictional responsibility. This pervasive ambivalence is particularly serious with respect to mental health, where the applicable programs and services must certainly encompass education, housing, employment, and social assistance, as well as health — all areas generally accepted as provincial/territorial responsibilities.

There was no ambivalence among the witnesses who appeared before the Committee and called for a clearly defined relationship with the federal government. The Canada-Aboriginal Peoples Roundtable process in 2004 was seen as a useful beginning for First Nations, Inuit and Métis in their call for self-determination based on indigenous rights.²³³ At the end of May 2005, the organizations representing various groups signed a number of statements that outlined specific measures to define further relationships with the Government of Canada.²³⁴

Witnesses spoke to the Committee of a new special relationship with the Government of Canada outside the current, often multiple-departmental interactions. Irene Linklater stressed the need to re-establish the special relationship with the Crown. She went on to say that First Nations want:

*...a direct relationship to, if not the Prime Minister then to the Privy Council; to primary decision-making bodies that have a fiscal arrangement directly with First Nations, and a direct First Nations-to-federal government relationship, with a nation-to-nation relationship...*²³⁵

14.6.2 Focusing Federal Departmental Efforts

At the federal level, responsibilities for the areas that determine positive mental health for Aboriginal peoples fall under the mandates of several departments. The picture is one of extreme fragmentation as multiple departments offer selective programs or services to particular groups of Aboriginal peoples. In most instances, the provision is exclusively to First Nations on-reserve; in others, only to First Nations off-reserve; some include Inuit and a few have a broader Aboriginal focus.

²³³ Canada-Aboriginal Peoples Roundtable. Final Roll-Up Report (by facilitators). http://www.aboriginalroundtable.ca/sect/ffr/index_e.html.

²³⁴ Indian and Northern Affairs Canada. (31 May 2005) News Release, “Federal Ministers and National Aboriginal Groups Participate in Joint Policy Retreat.” http://www.ainc-inac.gc.ca/nr/prs/m-a2005/2-02665_e.html.

²³⁵ 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

In 2005, 16 federal departments and agencies offered programs for Aboriginal people with total expenditures of approximately \$9.1 billion. Approximately two-thirds of all funds (about \$6 billion) are spent by Indian and Northern Affairs Canada. Health Canada accounts for close to \$2 billion, while other departments and agencies account for slightly more than \$1 billion.²³⁶ To date, there are no estimates of the total federal funding spent on mental health, mental illness and addiction among Aboriginal peoples.

Except for certain obligations specified in the *Indian Act* and administered by the Department of Indian and Northern Affairs, the federal government has permitted the development of a different foundation for each set of programs and services offered to Aboriginal peoples. Neither the *Constitution Act, 1867* nor the *Constitution Act, 1982* provide legislative authority to, or impose legal obligations on, the relevant federal departments or agencies.

At the federal level, responsibilities for the areas that determine positive mental health for Aboriginal peoples fall under the mandates of several departments. The picture is one of extreme fragmentation as multiple departments offer selective programs or services to particular groups of Aboriginal peoples.

The need to deal with several departments is viewed as a major, crippling impediment by Aboriginal peoples. For First Nations, the split of social programs and subsequent funding between two departments has created a gap in health and in the relationship of First Nations with the Crown and the Government of Canada:

To date, there are no estimates of the total federal funding spent on mental health, mental illness and addiction among Aboriginal peoples.

I would point out that there is a gap...in the relationship between the constitutional arrangements as set out by Canada, having established an administrative body called Indian Affairs, whose powers in this regard are now delegated to a federal department called Health Canada, to FNIHB, and that structure filters the money. —Irene Linklater²³⁷

For the Inuit, Onalee Randell emphasized that, because there are so many departments involved, departmental silos are reinforced, perpetuating unresolved disputes over jurisdictional responsibilities:

The need to deal with several departments is viewed as a major, crippling impediment by Aboriginal peoples.

It is also resulting in poor communication and coordination between not only health service providers from one region to another or from one community to another, but also from the intergovernmental departments. The housing people do not ever want to talk about how housing impacts mental wellness. The education people do not ever want to talk about how to revise or change

²³⁶ Indian and Northern Affairs Canada. 2005-06 Estimates: Report on Plans and Priorities, “Federal Partners.” http://www.tbs-sct.gc.ca/est-pre/20052006/INAC-AINC/pdf/INAC-AINCr56_e.pdf

²³⁷ 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

*curriculum to assist students to have the self-esteem and coping skills they need.*²³⁸

For Métis, the problem is that there is simply no departmental focus or concentrated governmental attention. Neither Indian and Northern Affairs Canada nor Health Canada assume specific responsibility. According to Gloria Laird, however, Co-Chair, Alberta Mental Health Board, Wisdom Committee, people are beginning to look at ways to develop a departmental focus in relation to the health and health service needs of Métis people.²³⁹

14.6.3 Recommendation for Action

The Committee recognizes that if any strategy and action plan are to be successfully implemented, this jurisdictional ambivalence needs to be sorted out, or at least replaced with clear statements of where responsibilities lie. The present reality is that Aboriginal peoples are very mobile and cross jurisdictional boundaries frequently. Moving on and off reserve as well as between provinces and territories should not occasion a loss of continuity in the delivery of services which can lead, in turn, to a loss of the programs essential for mental health.

If any strategy and action plan are to be successfully implemented, this jurisdictional ambivalence needs to be sorted out, or at least replaced with clear statements of where responsibilities lie.

The Committee was told that all levels of government have consistently denied full responsibility for the deterioration of the overall health status of Aboriginal peoples. Such denial has led to the offloading of responsibilities, obscuring of factual information, and failure to develop methods for assessing progress toward better health, including mental health.

Moving on and off reserve as well as between provinces and territories should not occasion a loss of continuity in the delivery of services which can lead, in turn, to a loss of the programs essential for mental health.

An unprecedented level of both federal leadership and intergovernmental collaboration is necessary to address the epidemic of mental health problems, including suicide and addictions, in Aboriginal communities.

Witnesses indicated clearly that they want a more direct relationship with the Crown, through the Government of Canada, that enables them to take direct responsibility for their own health. But they want to do this as part of a relationship with the Government of Canada that recognizes the ability of Aboriginal peoples to control their lives if provided with sufficient resources and support.

The Parliament of Canada and the federal government have long-term responsibilities for the state of well-being of all citizens of Canada, including all Aboriginal peoples. An unprecedented level of both federal leadership and intergovernmental collaboration is necessary to address the epidemic of mental health problems, including suicide and addictions, in Aboriginal communities. Beyond the work to be undertaken by the proposed

²³⁸ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²³⁹ 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Canadian Mental Health Commission, it is imperative that the federal government initiate action immediately to address the mental health needs of Aboriginal peoples.

The Committee has considered several potential federal foci that would complement and support the work of the proposed Canadian Mental Health Commission. Despite parliamentary oversight provided through standing committees in both Houses and through occasional reports by the Auditor General, Aboriginal peoples' issues have not been examined sufficiently rigorously or continuously by Parliament. One option might involve the establishment of a Parliamentary Officer, similar to the Auditor General or the Commissioner of Official Languages, who would report directly to Parliament (rather than to the federal government or to an individual minister).

A second option, based on the Prime Minister's initiatives for the Canada-Aboriginal Peoples Roundtable process, would be to establish a permanent structure similar to the National Round Table on the Environment and the Economy. Constituted as an independent advisory body, this National Round Table functions as a coalition builder, working to reconcile the often opposing governmental, industry, and community positions.

The Committee believes, that the most pressing need is to coordinate federal efforts directed at improving the health and well-being of Aboriginal peoples in Canada.

The Committee believes, however, that the most pressing need is to coordinate federal efforts directed at improving the health and well-being of Aboriginal peoples in Canada. The establishment of a Cabinet Committee on Aboriginal Issues and a secretariat at the Privy Council Office, combined with the 2003 commitment to develop a report card on Aboriginal peoples, opens the door to greater direct recognition of the federal relationship with all Aboriginal peoples.

The Committee recommends:

95	<p>That the Government of Canada create an interdepartmental committee composed of deputy ministers in departments with responsibility for Aboriginal peoples, chaired by the Privy Council Office.</p> <p>That the interdepartmental committee prepare a report to be tabled in Parliament every two years on the impact of the work of these departments on the wellness of Aboriginal peoples, including but not limited to their mental wellness.</p> <p>That this Aboriginal wellness report include an inventory of all federal programs and services specific to each group of Aboriginal peoples, with information on spending and the impact on actual health outcomes achieved, including but not limited to mental health outcomes.</p>
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That the interdepartmental committee support working groups composed of First Nations, Inuit and Métis representatives to provide information, advice and verification of the report.

14.7 ACTION ON DELIVERY OF PROGRAMS AND SERVICES

Programs and services that are designed to maintain health, prevent ill-health, and/or restore health and function, also constitute a determinant of health for Aboriginal peoples. As noted earlier, specific federal programs and services relevant to the mental health of Aboriginal peoples are provided primarily to First Nations clients living on reserve. Often, by extension, they are provided also to Inuit clients, but seldom to non-status Indian and Métis clients.

Of the 16 federal departments and agencies that offer programs for Aboriginal people, primary responsibility rests with Indian and Northern Affairs Canada and Health Canada. Indian and Northern Affairs Canada is responsible for the administration of the *Indian Act* and is the major provider of basic services such as education, social assistance, housing, and community infrastructure to status Indians on reserve, and some Inuit communities. With respect to specific health services, Health Canada is responsible for the provision of primary care through nursing stations and health centres to First Nations and Inuit clients on reserves and in many remote and isolated communities. The Non-Insured Health Benefits Program offers assistance with drugs, crisis intervention and mental health counselling to eligible First Nations and Inuit clients regardless of residency when no other insurance coverage is available.

Witnesses emphasized a number of underlying premises essential to successful outcomes from any program and service relevant to mental health, including: community authority and control; cultural accommodation; and equity of access. Incorporation of these elements into program and service delivery would help build what Bill Mussell referred to as “promising practices”:

*We talk about our weaknesses, problems and issues, but seldom do we ever talk about our resources and what our strengths are and the good ways of our life. What are the promising practices that we live with? I tend to hesitate to use “best practices” because I think there is so much that we do not know. If we were to buy into the notion of best practices, I think we would be cutting ourselves off before we had a chance to truly identify, explore and discover what truly works.*²⁴⁰

14.7.1 Community Authority and Control

Most witnesses testified that community authority and control over programs and services is essential to successful outcomes. They insisted that Aboriginal communities must take control of their own destinies through oversight of the design of mental health programs

²⁴⁰ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

and services, their delivery and cultural appropriateness. Valerie Gideon argued that unless First Nations have a sense of ownership and control over a comprehensive set of mental wellness programs, any new investment or initiative would inevitably work against itself.

Others stressed the need for capacity building to identify the strengths and expertise within each Aboriginal family and community. For Bill Mussell, “the foundation of the approach is to build community capacity that is reliable, safe and helpful within the context of regional and provincial support.” He indicated:

Capacity needs to be built at all levels of the system: the individual; family communication and problem solving; peer-to-peer helping; support group models that reflect the reality of community networks and existing relationships; peer and other professionals to help staff at the community level who offer services based in the range of mainstream cultural and complementary approaches of healing and helping; regional resources, including highly skilled professionals such as psychologists willing to bring their skills to engage in a creative and collaborative process to develop new programs and services; and provincial services that provide a high level of specialized services to support the capacity-building needed in the communities.²⁴¹

Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch, Health Canada, also recognized that communities are seeking empowerment and control:

Witnesses insisted that Aboriginal communities must take control of their own destinies through oversight of the design of mental health programs and services, their delivery and cultural appropriateness.

I am absolutely convinced that better health outcomes will not be achieved unless we can support the communities in taking a more active role. Our strategy is to try to work with the provinces and the communities, using the federal government resources, to see if we can design a health system in which communities can play that role. I do not think that we will get the results, as technically proficient as we may be, unless we can build a health system that is seen to be driven by the community, supported by the community and, often, delivered by community members.²⁴²

He also noted that Health Canada is pushing for greater integration of federal services with provincial services to reduce duplication and problematic overlap, arguing that:

With regionally identified, regionally based and regionally delivered programs and services, Aboriginal peoples report difficulties in achieving full consultation and participation.

Most of the services we fund are delivered by First Nations and Inuit. Part of that process is to support them so that they can play an active and essential role

²⁴¹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁴² 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

*in the fundamental health care system in Canada, which is provincial or territorial.*²⁴³

Aboriginal peoples raised some concerns, however, about being pushed into the provincial (often regionally based) sphere. With regionally identified, regionally based and regionally delivered programs and services, Aboriginal peoples report difficulties in achieving full consultation and participation.

As Valerie Gideon pointed out:

*Especially in provinces where much of the decision-making is devolved to fairly independently operating regional health authorities, First Nations communities have to take on their responsibility to push the regional health authorities to be accountable to them for the type of services they provide to their members. The reality is that they do not have the capacity for that. Very few of the regional health authorities reach out to First Nations communities in their areas to develop relationships.*²⁴⁴

Onalee Randell emphasized that regional funding is not supportive of community-based programs:

*We seem to be in an era of federal funding that is not community-based; it is regional funding involving specific communities. In areas of mental wellness, this funding is insufficient. How do you define which community requires mental wellness programming? Is it the community that does not have the suicides or the community that has had four, five, six or seven suicides in that year?*²⁴⁵

14.7.2 Cultural Accommodation

Witnesses called for access to culturally appropriate health care and services that recognize the internal cultural diversity, even within each group. They called for cultural awareness training and orientation for mental health staff as well as other service providers, including teachers, police, and officials for social services and children's services.

Witnesses called for cultural awareness training and orientation for mental health staff as well as other service providers, including teachers, police, and officials for social services and children's services.

Elsie Bastien stated that understanding and accepting the diversity of Aboriginal peoples was central:

²⁴³ 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁴⁴ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁴⁵ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

*Mental health providers can only create an environment of culture safety for Aboriginal people if they have been trained to understand and accept the cultural, linguistic, tribal, geographical, economic, political and community context of the various Aboriginal communities. Failure to grasp the significance of these contextual factors often leads to stigmatization, misdiagnosis, and inappropriate treatment.*²⁴⁶

Tarry Hewitt and others provided a recurring focus on traditional healing practices as a significant factor in moving forward:

*Healing circles, culture-based and guided by an experienced, and in our case, academically trained Aboriginal who engages in traditional healing, are far more than a cosmetic overlay to “group sessions.” They are rooted in ceremonies and traditions that can only be performed by those from the Aboriginal community who possess a depth of knowledge and who are recognized within that community as being capable of leading healing circles.*²⁴⁷

Although witnesses agreed that more authority should be delegated to Aboriginal communities to customize services and foster solutions that are more culturally appropriate, they recognized some challenges. Tarry Hewitt acknowledged that supporting traditional skills:

*involves not only overcoming a non-Aboriginal bias in favour of conventional treatments and methods of delivery, but also the challenge of Aboriginal perceptions that, as a result of decades of paternalistic intervention, non-Aboriginal practices are superior.*²⁴⁸

As Sheila Levy pointed out, cultural traditions need to be blended with social realities:

*Looking backward in rose-coloured glasses has not helped. Inuit want the best of both worlds in which they live. Many Inuit with whom I work and whom I know well have pointed this out to me. They want evidence-based methods and approaches integrated with Inuit beliefs, ways and cultural knowledge.*²⁴⁹

Clearly, the differences in identity, in size and in geographical location of each group must be factored into any mental health strategy. Officials from Correctional Service Canada were asked if programs and services for Aboriginal offenders considered adjustment issues: for example, an individual who displays signs of mental health problems may simply be experiencing social adaptation problems arising from the fact that he or she comes from a different cultural and geographic background. Dr. Michael Bettman of Correctional Service

²⁴⁶ 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

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

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

²⁴⁹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

Canada indicated that the issues involved are very complex and good solutions are difficult to find:

*If you are looking at specific cultural treatments, and you are adding the dimension of urban versus rural, it becomes more complicated. That is why we embarked on, not so much recreating but building from the ground up, many of our programs for Aboriginal populations specifically — designed by Aboriginal people, often delivered by Aboriginal people for the overrepresented Aboriginal population in our federal system.*²⁵⁰

14.7.3 Equity of Access

Although the federal government asserts that there are reasonably comparable levels of service for Aboriginal peoples throughout the country, many witnesses insisted that this is not the case. They described an overall patchwork of programs and services for Aboriginal peoples depending on whether they are Indian, Métis, or Inuit, and whether they live on or off reserve, at a remote northern or a southern urban setting, in a specific province or territory. Furthermore, witnesses argued that providing provincial services comparable to those available to the general population to people whose overall health and wellness status is so much lower does not make sense. To achieve real health comparability, programs and services must be designed to enhance and build positive health status among Aboriginal peoples specifically.

Although the federal government asserts that there are reasonably comparable levels of service for Aboriginal peoples throughout the country, many witnesses insisted that this is not the case.

The Committee was reminded by Donna Lyon that the Métis are generally excluded:

*Within the Metis Centre, some 30 per cent of the Metis people make up the target of our Aboriginal population [but] they are not included in many of the initiatives available to First Nations people and possibly Inuit people as well. They are not included in the National Indian Health Board program. They have no access to the National Native Alcohol and Drug Abuse Program.*²⁵¹

Even for First Nations, there are problems with continuity depending on whether an individual is on reserve or off reserve in an urban setting. Irene Linklater pointed to residency requirements for reserve benefits:

To achieve real health comparability, programs and services must be designed to enhance and build positive health status among Aboriginal peoples specifically.

There is a residency issue there, that once you have been away in hospital for three months, then you no longer have that benefit; you must then go to the province. There are other complications that can arise, such as if you go away to school, or you leave and then you have palliative care requirements, you

²⁵⁰ 23 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/08ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁵¹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

*cannot go back to your community because medical services does not pay for your trip back home to die with dignity.*²⁵²

Within each jurisdiction, the delivery of health services to Canada's Inuit population varies with place of residence. Inuit argue that there are differences between those who live in the territories, where the federal government still assumes some jurisdiction, and the provinces with larger Inuit populations such as Quebec or Newfoundland and Labrador where the federal government sees a provincial obligation to provide northern services. As Onalee Randell explained:

*The First Nations and Inuit Health Branch provides prevention and promotion programs and in some cases, limited care and treatment programs to Inuit communities through the two territorial governments: for Inuit living in Nunavut and Inuvialuit, through the Nunavik Health and Social Service Board for Inuit in Quebec, and through the Labrador Inuit Health Commission for Inuit in Labrador. In Nunavik, for example, in northern Quebec, if someone requires significant mental health services, they are transported by Medivac to Montreal, to a provincial hospital, where they have developed a partnership or an agreement. In fact, Nunavik has one bed dedicated for Inuit in Montreal for mental health services.*²⁵³

14.7.4 Recommendation for Action

The Committee recognizes the need for “outside the box” thinking and innovative ideas that lead to programs with clear goals and clear ways of measuring progress or the lack of it. It is looking for some specific results from the \$200 million allocated for an Aboriginal Health Transition Fund following the September 2004 special meeting of the Prime Minister, First Ministers and Aboriginal leaders.²⁵⁴ This federal fund is to enable governments and communities to devise new ways to integrate and adapt existing health services to better meet the needs of Aboriginal people.

The Committee agrees with the need for a seamless system to promote well-being, not only for First Nations and Inuit, but for all Aboriginal people. The Committee is aware that many First Nations have accepted responsibility for the direct delivery of health care services. It further

The Committee recognizes the need for “outside the box” thinking and innovative ideas that lead to programs with clear goals and clear ways of measuring progress or the lack of it.

The Committee agrees with the need for a seamless system to promote well-being, not only for First Nations and Inuit, but for all Aboriginal people.

The Committee believes that programs and services delivered to all Aboriginal peoples will lead to more successful outcomes if the principles of cultural accommodation and equity of access are respected.

²⁵² 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁵³ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁵⁴ Government of Canada. (September 2004) Commitments to Aboriginal Health. http://pm.gc.ca/grfx/features/23-fmm_e.pdf.

recognizes the need for greater community involvement in the design and implementation of all programs and services directed to Aboriginal peoples, including, where possible, direct community authority and control over them. Moreover, the Committee believes that programs and services delivered to all Aboriginal peoples will lead to more successful outcomes if the principles of cultural accommodation and equity of access are respected.

The Committee does not expect the federal government to deliver all the required programs and services, but it does expect it to live up fully to its responsibility to ensure their provision. The federal government can do this either through direct delivery or by providing funding to the provinces specifically earmarked for Aboriginal peoples on a per capita and health status basis. Regardless of who is involved in the delivery of needed programs and services, the key is to have clear lines of authority and to monitor outcomes carefully. Adequate checks and balances and appropriately objective evaluation measures must be in place.

The Committee acknowledges that the logical consequences of the preceding arguments and evidence about jurisdictional responsibilities and program and service delivery strongly suggest the need for a completely different model of governance of the broad affairs of Aboriginal peoples in Canada. This new model must recognize that the time is ripe for serious consideration of a mechanism to include Aboriginal peoples in the decisions that affect their lives. The Committee also knows, however, that this new model cannot be a simple administrative reconfiguration. Nor can its development be proposed in the context of a report whose primary focus is the mental health and well-being of Canadians in general.

The Committee does not believe, therefore, that it is appropriate to propose any new entity or structure solely on the basis of the testimony heard during this mental health study.

The Committee does not believe, therefore, that it is appropriate to propose any new entity or structure solely on the basis of the testimony heard during this mental health study. It is prepared, however, to add its voice to support further work on the issues of governance and of administration for Aboriginal peoples. In particular, it acknowledges the need for greater autonomy for Aboriginal peoples in the design and delivery of programs and services that meet the needs identified by their communities.

At this time, then, the Committee recommends:

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| 96 | <p>That the Government of Canada work closely with the provinces/territories and representatives from the different Aboriginal communities to develop programs and services deemed necessary by Aboriginal peoples.</p> <p>That criteria for the design and delivery of identified programs and services take into account the importance of enhancing community involvement, and of ensuring cultural accommodation and equity of access.</p> |
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That any delivery mechanism for these programs and services include ongoing oversight and public evaluation of outcomes by the funding body.

That the criteria for funding and accountability provisions be made public.

14.8 SPECIFIC INITIATIVES

14.8.1 Renewal of the Aboriginal Healing Foundation

Many witnesses stressed the need to build on the efforts of the Aboriginal Healing Foundation and called for its long-term renewal. The Aboriginal Healing Foundation was established in 1998 with a 10-year mandate to address issues of physical and sexual abuse related to residential schools.²⁵⁵ It has a special place as the first national Aboriginal organization representative of all groups working on Aboriginal-initiated and Aboriginal-implemented community projects. According to Gail Valaskakis, it played a critical role in providing partnerships, in identifying and filling the gaps in services, and in involving survivors and those who are intergenerationally affected.²⁵⁶

Representatives of First Nations and Inuit spoke about the need for long-term renewal of the Foundation's funding in order to expand and sustain community healing projects. For Shean Atleo, Chief A-in-chut, B.C. Regional Chief, its funding of healing efforts at the community level were crucial to increased emotional wellness in his community:

*Through the 1990s, we saw a decline in suicide attempts and completions amongst the Nuu-chab-nulth. While there is no one factor that we can point to, I know that the work of the Aboriginal Healing Foundation was tremendous for our people. The foundation allowed for community-based design and delivery of healing.*²⁵⁷

For the Inuit, although late in coming to the process, the programs that resulted from the Aboriginal Healing Foundation filled a gap:

Inuit reviewing the Aboriginal Healing Foundation program see the need to expand it, to have it not only focus on residential schools and the negative impact of those schools relating to abuse but also the negative impact relating to language loss, cultural loss and the loss of parenting skills. This information is from Inuit who have provided information that they were not abused in residential schools; they believe the schools were a positive experience. However,

²⁵⁵ Aboriginal Healing Foundation. <http://www.ahf.ca/newsite/english/about.shtml>.

²⁵⁶ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁵⁷ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

they did lose their language. They feel some loss of culture. —Onalee Randell²⁵⁸

The Foundation's funding ends in 2007 and, for many groups, this constitutes another example of the instability created by short-term funding. By the time that communities develop the capacity to apply for funding through the Foundation, none will be available:

For the first three years of that funding, communities tried to figure out what they needed and how to implement it, and even to get assistance with writing the proposals, which the Aboriginal Healing Foundation provided. By the time initiatives with three- to five-year timelines are operational in communities, the funding has run out. It is hard to get qualified staff to give up permanent jobs to go into a project that may end in two years. —Onalee Randell²⁵⁹

Gail Valaskakis confirmed that the Inuit were late in accessing the programs of the Aboriginal Healing Foundation. She also noted that:

Metis have been even more difficult to reach and are a target. Many areas of society that are invisible to all of us, such as the homeless and the incarcerated, have been difficult to reach as well...²⁶⁰

Data from two studies related to the costs of abuse and the value of healing were used by Valaskakis to provide evidence that "healing is cost effective, personally effective and socially effective." According to the Canadian Incidence Study of Reported Child Abuse and Neglect, child abuse is extremely costly and when "applied to the residential school issue, it shows that Canadian society pays about \$440 million per year on incarceration, social services, special education and health."²⁶¹

The second study cited by Valaskakis looked at healing in relation to incarceration on the Hollow Water Reserve. It found that healing is more cost-effective than incarceration, and actually lowers its rate:

For every \$2 spent on the community holistic healing circle program at Hollow Water, the federal and provincial governments save \$6 to \$16 on incarceration fees. That is a conservative estimate that was done by holding the cost of the system constant and adding the cost of one person to the system.²⁶²

²⁵⁸ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁵⁹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁶⁰ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁶¹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁶² 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

The Aboriginal Healing Foundation is credited with providing the type of integrated approach that has a better chance of working than the stove-piped, or silo-structured, model currently in existence. As Gail Valaskakis testified:

*To date, the Aboriginal Healing Foundation has invested \$437 million in community-based projects, ranging in type from awareness and prevention to actual healing services, including long-term healing services in residential treatment in trauma centres and programs for addiction.*²⁶³

She called for support for the Aboriginal Healing Foundation on a long-term basis:

*An endowment of \$600 million would support a 30-year healing strategy with a 2.5 per cent inflation rate and a 5 per cent return on that investment. Thus, \$28.7 million per year would be available for community-funded projects. This would mean that by year 30, the Aboriginal Healing Foundation would have invested \$1.2 billion in healing.*²⁶⁴

The Committee commends the work done by the Aboriginal Healing Foundation and agrees with those who call for a long-term commitment to its work. It recognizes the need to continue to address the legacy of abuse and the intergenerational and other impacts of social, psychological, cultural and spiritual injuries. It supports the goals of acknowledgement, redress, healing and reconciliation.

The Committee recommends:

97	<p>That the Government of Canada renew the mandate of the Aboriginal Healing Foundation and provide funding for another three years.</p> <p>That, on a priority basis, the Canadian Mental Health Commission (see Chapter 16) and its Aboriginal advisory committee undertake an evaluation of the efficiency and effectiveness of the Aboriginal Healing Foundation.</p> <p>That the results of the assessment include recommendations concerning the future of the Aboriginal Healing Foundation and be made public.</p>
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14.8.2 Increase of Health Human Resources

All witnesses acknowledged that mental health and the prevention and treatment of mental illness depend upon integrated, interdisciplinary care from a variety of health care providers. In Aboriginal communities, the acute shortage of family physicians, nurses, psychiatrists,

²⁶³ 21 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/23evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁶⁴ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

psychologists, social workers and other professionals seriously affects the delivery of appropriate care and services.

Many emphasized the need for mental health professionals who are themselves Aboriginal, or at least are knowledgeable about Aboriginal cultures. Arnold Devlin recounted a story of how psychiatrists educated and oriented to a different culture and life experience reacted to Aboriginal peoples living in northern Ontario:

At one time psychiatrists in the Nishnawbe-Aski area were educated in Scotland and England. They would arrive from the University of Toronto to work in the area. They classified people with many strange multiple personality disorders and exotic mental illnesses. One time I spoke to a lady after she had seen the psychiatrist and asked what she had said to him. She said that she had simply told him about her life and he gave her medications to take. That is the reality and, often, the worldview and the sense of values and beliefs is very different so the psychiatrist's paradigm missed it all together and did not click on what was happening to that person.²⁶⁵

According to Rob Wipond, providers who are Aboriginal can counter cultural biases that can affect diagnoses. In refuting the claim that Aboriginal communities suffer significantly higher rates of mental illness, he asserted:

Ample research has shown that culture, lifestyle and spiritual difference are crucial factors in diagnoses and forced treatment. If you start seeing gods and demons and believe you are approaching a mystical breakthrough, it is not at all likely that a psychiatrist is going to support your exploration. He is going to call you "delusional," probably "schizophrenic" and tranquilize you.²⁶⁶

Many emphasized the need for mental health professionals who are themselves Aboriginal, or at least are knowledgeable about Aboriginal cultures. Providers who are Aboriginal can counter cultural biases that can affect diagnoses.

The number of Aboriginal workers actually working in the field of mental health, and their particular concerns, have not been fully quantified. For example, one Aboriginal psychiatrist, Cornelia Wieman, who returned to her Six-Nation reserve to practise medicine, found that the community could not afford to pay her a salary commensurate with her training and expertise because it lacked the money to do so.

Several witnesses emphasized the need for innovation in addressing the shortages of Aboriginal people in the mental health field, pushing for thinking "outside the box."

Dr. Arthur W. Blue noted that the Native Psychologists of Canada is a small organization with less than 20 members. He identified the need for a supportive institution responsible for training native clinical psychologists to achieve successes similar to the movement "from

²⁶⁵ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁶⁶ 6 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/18eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

51 native physicians 20 years ago to 250 today.” He went on to emphasize the important role for psychologists:

*It is not only treatment but it is also prevention. Not only do they do psychometrics, psychotherapy, group psychotherapy, abuse treatment, both physical and substance, they are the best educated mental health professionals available in Canada, and should be working hand in glove with mental health workers, social workers, physicians and the band council.*²⁶⁷

Many Aboriginal people do not succeed in education and in pursuing careers as health workers. Several witnesses emphasized the need for innovation in addressing the shortages of Aboriginal people in the mental health field, pushing for thinking “outside the box.” Tarry Hewitt described a legal training program for 10 students in Nunavut at Akitsiraq Law School in collaboration with the University of Victoria Law School, the University of Ottawa, the Government of Canada and the Government of Nunavut. She also mentioned the collaboration of the University of Cape Breton with First Nations communities in Nova Scotia to bring the university classroom to the communities:

*Some of the obvious benefits to the communities include not having to leave home and family responsibilities to pursue post-secondary education and the ability to be educated in familiar versus intimidating surroundings. This leads to higher rates of retention. The educational institution benefits from this collaboration by giving visiting professors a chance to become more knowledgeable about First Nations communities and customs.*²⁶⁸

Debbie Dedam-Montour, Executive Director, National Indian and Inuit Community Health Representatives Organization, pointed out that the training for a community health representative (CHR) has changed as part of the health transfer process from one offered by Health Canada to one under band jurisdiction. She noted that: “Some colleges have CHR programs, such as the course at Portage College. Alberta and Manitoba offer courses but they are fragmented.”²⁶⁹ The current goal is to set up core competency training programs for the CHR in each of the provinces.

The issue of accreditation, of determining who is authentic and qualified to provide effective healing, was also addressed by Tarry Hewitt:

There is capacity within the Aboriginal communities to identify men and women who engage in traditional healing practices, who routinely seek guidance from elders and medicine men and women and who would be appropriate facilitators of healing circles and other traditional methods. Structures already

²⁶⁷ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

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

²⁶⁹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

*exist within the Aboriginal communities to vet the recognized ability of healers who would provide services in an accountable manner.*²⁷⁰

The accreditation process is important for traditional healers who seek funding by Health Canada as health workers in Inuit and First Nations communities. According to Ian Potter, some system of standardization is needed:

*We have some limitations with respect to funding traditional medicine because there is no system in place that defines who is a traditional medicine specialist. In other countries — and it is something we have tried to encourage First Nations and Inuit people in Canada to look at — the people who practice traditional medicine have organized themselves to certify who is a legitimate provider of these services. So far, we have not been able to achieve that. There is a difficulty, as liability issues arise; if we pay for something, we should know what standard we are paying for.*²⁷¹

The Committee knows that successes in the area of Aboriginal health human resources have been achieved over the last few decades. It is aware of the efforts of both Health Canada's Indian and Inuit Health Careers program and the National Aboriginal Achievement Foundation. It also recognizes the positive step represented by the announcement of \$100 million for an Aboriginal Health Human Resources Initiative as a result of the September 2004 special meeting of the Prime Minister, First Ministers and Aboriginal leaders.

The Committee believes that a special effort must be made to increase the number of Aboriginal people pursuing health care careers in the mental health field. Culturally sensitive approaches for training and retaining Aboriginal individuals as psychiatrists, psychologists, mental health nurses, social workers and others are needed urgently.

The Committee believes, however, that a special effort must be made to increase the number of Aboriginal people pursuing health care careers in the mental health field. Culturally sensitive approaches for training and retaining Aboriginal individuals as psychiatrists, psychologists, mental health nurses, social workers and others are needed urgently.

The Committee recommends:

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| 98 | <p>That the Government of Canada work with the provinces and with universities and colleges to establish clear targets for Aboriginal health human resources.</p> <p>That the Government of Canada finance specific access for Aboriginal students seeking careers in mental health.</p> |
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²⁷⁰ 16 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/22evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁷¹ 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

That the Government of Canada increase its financial and social support for Aboriginal students engaged in these studies.

14.8.3 Suicide Prevention

The rates of suicide among Aboriginal peoples are significantly higher than for the general population in Canada. In 1995, the Royal Commission on Aboriginal Peoples estimated that suicide rates across all age groups of Aboriginal people were on average three times higher than in the non-Aboriginal population. For registered Indians, the suicide rate was 3.3 times the national average; for Inuit, it was 3.9 times. Among Aboriginal youth aged 10 to 19 years, the suicide rate was five to six times higher than among their non-Aboriginal peers.²⁷²

Inuit regions had rates of suicide “which are 11 times the national average.”

Data collection and analysis, knowledge translation and dissemination of accurate information are considered essential for early detection and effective intervention.

Witnesses told the Committee that the statistics do not provide the complete picture and that many incidents have gone unreported. According to Debbie Dedam-Montour, most suicide statistics do not account for suicides wrongly reported as accidental deaths, nor do they include incomplete suicides (suicide attempts). Witnesses stated that by 2005, the reported rates of suicide were much higher. Larry Gordon pointed out that Inuit regions had rates of suicide “which are 11 times the national average.”²⁷³ James Morris, speaking about the 32 isolated First Nations served by the Sioux Lookout First Nations Health Authority in northern Ontario, reported the extremely high incidence of suicide in the region:

For young people, suicide prevention was seen as an area that needed urgent attention.

*The national rate for suicide for young people in Canada is 0 to 14.9 per 100,000. In some of our communities, the rate is 42.5 per 100,000. The suicide rate is 398 per 100,000 in the age group 15 years to 19 years. The national average is 12.9 per 100,000.*²⁷⁴

For all groups, surveillance, data collection and analysis, knowledge translation and dissemination of accurate information are considered essential for early detection and effective intervention. Onalee Randell explained:

The lack of Inuit-specific data makes it difficult for Inuit to work together across Canada. We have community-level data provided by regional boards on suicide incidence. There is no national reporting for Inuit suicide. It is

²⁷² Royal Commission on Aboriginal Peoples. (1995) Choosing Life: Special Report on Suicide Among Aboriginal Peoples.

²⁷³ 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁷⁴ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

*anecdotal from the communities. We do not have the same level of data on incidence of attempts or incidence of mental illness*²⁷⁵

For young people, suicide prevention was seen as an area that needed urgent attention. Jason Whitford reported that:

...of the close to 300 people we have met with and talked to about suicide prevention, probably 95 per cent had had suicide directly impact their family or a close friend.

*When working with the mainstream, it was the reverse. It was probably 10 per cent who had a family member or a close friend die by suicide.*²⁷⁶

Many factors contribute to suicide. A 1995 report by the Royal Commission on Aboriginal Peoples identified situational, socio-economic and culture stress as the major risk factors for suicide among Aboriginal peoples. Mental illnesses related to psycho-biological factors such as anxiety disorders or schizophrenia were documented infrequently.²⁷⁷ This was reiterated by Arnold Devlin:

The majority of witnesses talked about suicide as the end product of a series of very fundamental problems, all of them incorporated within the broad compass of the determinants of health.

If you look at suicide in First Nation communities, I am not sure that you can use the mental illness model. I think that depression and substance abuse contribute, but there are other factors that are integral to that desperation, that despair, and that loss of hope that actively contribute to suicide.

*The 10 year-old or 14 year-old who commits suicide is not suffering from a mental illness. They have given up. If we look at it from a mental illness model, we miss that sense of historical dynamics.*²⁷⁸

The majority of witnesses talked about suicide as the end product of a series of very fundamental problems, all of them incorporated within the broad compass of the determinants of health. They argued that resources should be devoted at an earlier stage toward stopping or easing the problems contributing to the high rates of suicide in Aboriginal communities. Ron Evans, Chief of Norway House Cree Nation, insisted:

We do not wish to recite the devastation visited upon our peoples. We do wish that you understand that our peoples continue to suffer from what our Elders and healers say is unresolved grief over the generations. Some refer to this situation or condition as historic trauma or collective grief, and it manifests

²⁷⁵ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁷⁶ 31 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁷⁷ Royal Commission on Aboriginal Peoples. (1995) Choosing Life: Special Report on Suicide Among Aboriginal Peoples.

²⁷⁸ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

*itself in the high proportion of our people addicted to alcohol, drugs, gambling or other forms of addiction and in high suicide rates, especially among our young people.*²⁷⁹

James Morris, Executive Director, Nodin Counselling Services, in reference to some root causes of suicide, observed:

Some of the causes are oppression and colonization, going back 100 years. The problem cannot be understood by anybody who has not been colonized or oppressed. We understand because we have experienced it.

*Part of the problem is the residential school system. Once again, if you have never been a residential school victim, you do not know how it is because you do not know how it feels. It is the same with racism. Racism is everywhere. Once again, if you have never been a victim of racism, you do not know what it is. If you are not affected by it, if you are not hurt by it, you do not respond to it. When you see somebody victimized by racism, you do not do anything because it does not bother you. We experience racism every day, everywhere. It is a fact of life.*²⁸⁰

People talked about the need to integrate physical and mental health programs and services to reduce the tendency to define issues in silos and to “stove-pipe” services. Sheila Levy emphasized that suicide cannot be separated from other issues:

People talked about the need to integrate physical and mental health programs and services to reduce the tendency to define issues in silos and to “stove-pipe” services.

*There is a tendency to view suicide, violence, addictions, abuse and mental health as separate issues. These problems receive separate funding while we should address the underlying commonalities in these issues.*²⁸¹

Onalee Randell supported greater integration of programs at the community level for more positive outcomes:

*Individuals sent out for addictions treatment are returned to the communities without health or social services being notified of their return or any follow-up of the outcomes of their treatment. Children and youth who have had suicide attempts and are sent out of their communities for medical attention are returned to the communities with no follow up and, in some cases, no notification of health centre nurses who sent them out.*²⁸²

²⁷⁹ 31 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁸⁰ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁸¹ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁸² 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

The Committee is extremely concerned about the high rates of suicide among Aboriginal peoples. It is more than a decade since the Royal Commission on Aboriginal Peoples highlighted this and the resultant devastation for Aboriginal communities in its special report. Instead of improvement, the Committee heard about deterioration.

The Committee observes that, starting in 2005, Health Canada is to allocate \$65 million over five years to a new National Aboriginal Youth Suicide Prevention Strategy; the money flows at a rate of \$15 million per year from year two to year five. It includes funding for First Nations on reserve and Inuit to support communities at risk, through crisis response and stabilization. Some additional funding for research will look at off-reserve Aboriginal youth.

The Committee is extremely concerned about the high rates of suicide among Aboriginal peoples.

The Committee wants concrete action to address the appalling suicide rate among Aboriginal children and adolescents.

The Committee sees a role for the proposed Canadian Mental Health Commission in helping to develop consistent standards and protocols, in understanding risk factors and in organizing a national suicide research agenda. But, most importantly, it wants concrete action to address the appalling suicide rate among Aboriginal children and adolescents. The Committee believes that this work would best be undertaken by the Canadian Mental Health Commission in close cooperation with other organizations such as the Canadian Institutes of Health Research and the Canadian Institute for Health Information.

In view of the clear need for immediate culturally appropriate actions, the Committee recommends:

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- 99 **That the Canadian Mental Health Commission (see Chapter 16), as a high priority, identify measures to reduce the alarming suicide rates amongst Aboriginal peoples.**
- That identification of these measures be a component of its priority action on an Aboriginal wellness and healing strategy.**
- That the Government of Canada allocate a designated suicide fund that accommodates the distinct needs of each group of Aboriginal peoples.**
- That the fund include specific allocations for implementing any measures identified by the Canadian Mental Health Commission as well as for increased research by the Canadian Institutes of Health Research and for specific data collection by the Canadian Institute for Health Information in collaboration with the National Aboriginal Health Organization.**

14.8.4 Reduction of Alcohol and Substance Addiction

As with suicide, witnesses talked about the interrelationship between alcohol and/or substance abuse and other social problems. James Morris reiterated that “All these social problems, suicide, sexual abuse, family violence, alcohol and drug abuse, are manifestations of deeper problems.”²⁸³

The Assembly of First Nations supported the need for appropriate funding to develop and administer regional treatment facilities for those who abuse solvents and those with drug addictions.

Debbie Dedam-Montour argued that “the broad term of ‘family violence,’ which is sexual, physical, emotional and psychological abuse, and neglect...has had a domino effect because it leads sufferers to self-medicate with alcohol or any other harmful substances and to involvement with correctional institutions.”²⁸⁴

The Assembly of First Nations supported the need for appropriate funding to develop and administer regional treatment facilities for those who abuse solvents and those with drug addictions. Valerie Gideon told the Committee about proposals:

Inuit communities have a need for specific alcohol and addictions programs that are culturally based and use both harm reduction and abstinence models.

*...to look at developing or creating new treatment centres that would have a broad mandate beyond strictly alcohol, for example, or some of the more well-known drugs to look at some of the emerging addictions, such as crystal meth, for example, that play a pivotal role in mental health and suicides in our communities.*²⁸⁵

Donna Lyon noted the lack of sufficient funding by Health Canada for addiction services:

*There are long waiting lists to attend counselling and insufficient funding for patient transportation. Much of the funding is prioritized toward acute care operations and short-term crisis intervention.*²⁸⁶

Inuit communities have a need for specific alcohol and addictions programs that are culturally based and use both harm reduction and abstinence models:

There needs to be an increased number of Inuit addiction counsellors and early interventions. We need to have after-care and follow-up services in communities. No longer are people happy with going to six-week treatment centres and then

²⁸³ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁸⁴ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁸⁵ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁸⁶ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

coming home to the same situations; the same overcrowding, the same high costs and no supports. —Onalee Randell²⁸⁷

The Committee supports the message that the connected nature of alcohol and other substance abuse and suicide, along with other social problems, requires a coordinated population health approach. Careful evaluation of what works best to achieve positive outcomes is essential. It is extremely important, therefore, that the proposed Canadian Mental Health Commission work very closely with other organizations such as the Canadian Institutes of Health Research and the Canadian Centre for Substance Abuse.

The connected nature of alcohol and other substance abuse and suicide, along with other social problems, requires a coordinated population health approach.

The Committee recommends:

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| 100 | <p>That the Canadian Mental Health Commission (see Chapter 16) identify measures to reduce the alarming alcohol and substance addiction rates amongst Aboriginal peoples.</p> <p>That identification of these measures be a component of its priority action on an Aboriginal wellness and healing strategy.</p> <p>That the Government of Canada allocate a designated fund for addiction that accommodates the distinct needs of each group of Aboriginal peoples.</p> <p>That the fund include specific allocations for implementing any measures identified by the Canadian Mental Health Commission as well as for increased research by the Canadian Institutes of Health Research and for specific data collection by the Canadian Centre for Substance Abuse in collaboration with the National Aboriginal Health Organization.</p> |
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14.9 ASSESSING DATA AND DOLLARS

Two things are important to the success of any strategy — money and data on what is happening. Money alone will not fix the poor health status of Aboriginal peoples, although there is no doubt that more must be spent. It is critical to have comprehensive data on where and on what money is currently being spent and what outcomes are the result. New approaches to the collection of information and evidence are needed both to improve care and to inform new approaches about how best to distribute the money to achieve the greatest results.

²⁸⁷ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

14.9.1 Expanded Data

The foundation of any effective strategy or action plan is data. Over the last decade, many reports — from those emanating from the Royal Commission on Aboriginal Peoples to those issued following the recent First Ministers' meeting with Aboriginal leaders — have called for development of a framework to collect and report comparable information across all Aboriginal groups.

There is no ongoing data collection on the prevalence of mental illness and addictions among Aboriginal people.

The most definitive source of data about persons with disabilities in Canada (Participation and Activity Limitation Survey, PALS) provides no information specific to Aboriginal peoples.

Although the Government of Canada, as part of the Canada-Aboriginal Peoples Roundtable process in 2004, committed itself to the development of an Aboriginal report card, there is no ongoing data collection on the prevalence of mental illness and addictions among Aboriginal people. Witnesses acknowledged that federal departments have difficulty in getting comprehensive data relating to mental health on all Aboriginal populations. For First Nations and Inuit, Indian and Northern Affairs Canada, Health Canada and Correctional Service Canada all offer specific programs and services, but the data analyses relating to them are limited.

At Social Development Canada, the most definitive source of data about persons with disabilities in Canada (Participation and Activity Limitation Survey, PALS) provides no information specific to Aboriginal peoples. Although suggesting that rates of disability — including mental disabilities — may be much higher among Aboriginal persons than in the rest of the population, Cecilia Muir, Director General, Office of Disability Issues, explained:

In terms of data, we do not have specific data. I have talked about the population size, but it is not specific to Aboriginal persons. They were not over-sampled, so we do not have greater detail about the [incidence] in the Aboriginal population.²⁸⁸

Witnesses stressed the need for better data to support informed decisions that would contribute to wellness. They called for baseline data from which specific targets could be established. They urged greater accountability and transparency by governments, providers and others so that progress toward established goals could be tracked and measured over time. Elsie Bastien pointed out:

Witnesses called for baseline data from which specific targets could be established.

We need to develop baseline data of program and service delivery usage by Aboriginal populations. It is important that mechanisms be developed to systemically collect and analyze longitudinal Aboriginal health information. A

²⁸⁸ 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

*centralized focussed approach will be helpful to coordinate, foster comparability, and create linkages among Aboriginal health and data sources.*²⁸⁹

Witnesses emphasized the need for data specific to each group. The First Nations regional longitudinal national health survey was held out as a potential vehicle for ongoing collection of mental health data and monitoring of the equality of access to mental health services in First Nations communities. Housed within the First Nations Centre at the National Aboriginal Health Organization, the regional health survey is community-based, the only survey that goes on reserve and collects data directly from First Nations people.

Witnesses emphasized the need for data specific to each group.

There is a limited amount of Inuit- and Métis-specific data on mental health, as in other areas of health. It is very difficult to measure progress when data are absent or not available in sufficient detail.

*For Inuit in particular, our information is missing or mixed in with the data that includes other Aboriginal peoples. Without the correct Inuit health stats, development and evaluation of programs and services will not be based on reliable evidence. —Larry Gordon*²⁹⁰

*Across the board, while we are gathering data and accumulating an evidence base for First Nations and Inuit, Metis lag far behind in gaining initial basic baseline data. —Bernice Donney*²⁹¹

One witness stressed the need for careful analysis of data, taking into account factors such as culture. Elsie Bastien noted that an evaluation of service delivery can measure outcomes as poor based on an imperfect theory:

An error or poor outcome is an indicator of incomplete data or an inadequate hypothesis that did not result in a successful completion of a certain purpose and/or intent. It is imperative that culturally appropriate program indicators are included within the proposed environmental scan.

*[...] An accurate picture would be data not generated from a Western medical model, which is our current practice, but generated from an Aboriginal world view on health and wellness.*²⁹²

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

²⁸⁹ 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁹⁰ 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁹¹ 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁹² 9 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/21evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

The Committee believes that, without a clear, complete and accurate picture of the current situation facing Indian, Inuit and Métis populations, it will be extremely difficult to set standards and targets and provide the required resources for programs and services that will be effective in improving the overall wellness of Aboriginal peoples. In particular, the Committee recognizes the importance of developing data that will provide the baseline against which new investments can be tracked over time and the outcomes of new programs and services measured.

The Committee does not understand how federal departments, knowing the abysmal health status of Aboriginal peoples and the fact that this population is universally considered to be at risk, could have failed to collect, or to support others in collecting, the data required to develop a strategy to address the problem in a meaningful way and to measure progress subsequently with respect to outcomes.

The Committee does not understand how federal departments, knowing the abysmal health status of Aboriginal peoples and the fact that this population is universally considered to be at risk, could have failed to collect, or to support others in collecting, the data required to develop a strategy to address the problem in a meaningful way and to measure progress subsequently with respect to outcomes.

The Committee recommends:

101	<p>That the Government of Canada work with the National Aboriginal Health Organization to assess the appropriateness of the First Nations regional health survey for use as a model for data collection for other Aboriginal peoples.</p> <p>That the Canadian Institute for Health Information be encouraged to provide analysis of health determinants data related to each of the Aboriginal peoples.</p> <p>That the Canadian Mental Health Commission (see chapter 16) work with the Canadian Institute for Health Information to improve understanding of mental health causes and outcomes.</p>
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14.9.2 Transformed Funding

Witnesses stressed repeatedly that the key to capacity is adequate, flexible and ongoing funding. In particular, multi-year sustainable funding is essential to counter the past experience of communities that devoted resources to set up a program only to discover that the available funding would support it for only a year or two. Onalee Randell emphasized that:

Multi-year sustainable funding is essential to counter the past experience of communities that devoted resources to set up a program only to discover that the available funding would support it for only a year or two.

The short-term unstable and uncertain funding causes incredible barriers to the delivery of mental wellness programs. [...] Multi-year flexible funding is

*required. It is difficult for small communities to develop programs and not know if those programs will be funded the next year.*²⁹³

Valerie Gideon urged that funding and reporting structures be transformed:

*...so that they are enabling tools rather than barriers to the implementation by communities of holistic approaches to mental wellness. An example of that transformation is multi-year flexible funding arrangements and reporting based on outcomes versus administrative data.*²⁹⁴

Irene Linklater noted that integrated models of funding between federal agencies are being introduced that allow for the support of comprehensive programs with long-term sustained funding and rigorous accountability requirements:

*...there is a new contribution model between First Nations and Inuit Health Branch and Indian and Northern Affairs Canada that looks at block funding, multi-year arrangements. We are encouraged by that process.*²⁹⁵

The First Nations reporting requirements established by the federal government were criticized by the Auditor General of Canada as being onerous; she commented that they “are a significant burden, especially for communities with fewer than 500 residents. We estimated that at least 168 reports are required annually by the four federal organizations that provided the most funding for major federal programs.”²⁹⁶

Needs-based funding formulas that would provide stable, predictable funding to facilitate financial planning are necessary.

Needs-based funding formulas that would provide stable, predictable funding to facilitate financial planning are necessary. Valerie Gideon supported the movement to more targeted and consolidated funding for First Nations health, a focus on block funding and the development of a “system of healing centres and lodges under First Nations control to bridge jurisdictions and individual ministries, and to pool both health and social resources from all sources.” She maintained that this funding would be most effective with:

*...an increased transfer of funding to First Nations communities to develop and maintain their own health centre facilities and, underneath that, the mental health services with strategic linkages to provincial and territorial jurisdictions.*²⁹⁷

²⁹³ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁹⁴ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁹⁵ 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁹⁶ Auditor General of Canada. (December 2002) Streamlining First Nations Reporting to Federal Organizations. <http://www.oag-bvg.gc.ca/domino/reports.nsf/html/20021201ce.html>.

²⁹⁷ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

The overall allocation of money for mental health purposes was challenged by several witnesses. Donna Lyon called into question the current funding focus on “affordability and not need,” when the need is so great for mental health services.²⁹⁸

According to Ron Evans, funding can be a source of wellness. He linked research from Harvard University on socio-economic development and from British Columbia on suicide prevention in First Nations to demonstrate the interconnected nature of economic and cultural stability in communities:

*The Harvard project on Native American tribes found, through several years of onsite work with First Nations in U.S. and Canada, that business success in First Nations in Canada and tribes in the United States depend upon a few factors such as a stable government and regulations, adequate funding, and, importantly, the cultural match of the business to the community. Similarly, the ongoing 14-year study of Chandler and Lalonde, “Cultural Continuity as a Hedge Against Suicide,” found that First Nations who had control of essentially government functions such as education, health, community services, who worked to resolve land claims and who actively practised their cultural traditions, had little to no suicide.*²⁹⁹

14.9.3 Funding for Youth

Irene Linklater was one of several witnesses to talk about the lack of youth-specific funding and the problems created when program funding is delayed. Referring to the importance of youth councils that represent young people in communities, she stated:

One of the problems that they have is access to funding. There is really no specific funding for youth engagement at the community level for, say, the youth suicide strategies.

*In Manitoba here, we have funding for youth through the Assembly of Manitoba Chiefs, but every year we fight for funding. We sometimes do not get our funding until October.*³⁰⁰

While Jason Whitford, Coordinator, Youth Council, Assembly of Manitoba, acknowledged that it does not always take a lot of money to do positive things in a community, any discontinuity in funding makes it more difficult to operate. Even the Keewatin Winnipeg Youth Initiative, recognized as best practice and funded by the Urban Multipurpose Youth Centres Initiative out of Heritage Canada, experiences funding problems:

We are waiting for funding once again for the year. We will probably end up losing about five months out of the year. However, based on past experience,

²⁹⁸ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

²⁹⁹ 31 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

³⁰⁰ 1 June 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evc-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

*we are going to just continue to deliver programs and services for urban Aboriginal youth and convince the management of AMC to support us in operating that project.*³⁰¹

For the Inuit as well, although the presence of and participation by youth is seen as crucial to community wellness, particularly to suicide prevention, the funding is erratic. Larry Gordon recounted how the National Inuit Youth Council has been active in role modelling and in suicide prevention:

*The funding provided to Inuit youth for these important initiatives is provided year to year with no guarantees, despite the success the work had in outreach to Inuit youth who are the most at-risk population for suicide in all of Canada.*³⁰²

As part of the September 2004 federal, provincial and territorial Health Agreement, the federal government announced new funding of \$65 million allocated over five years for an Aboriginal youth suicide prevention strategy. Ian Potter indicated that discussions about its distribution were ongoing:

*We are working on the program jointly with the Assembly of First Nations, the Inuit Tapiriit Kanatami and with input from other national Aboriginal organizations, provinces and territories and federal departments. This strategy will support communities in stopping youth from becoming suicidal, reaching youth who are at risk of committing suicide and preventing suicide clusters in the aftermath of a completed suicide.*³⁰³

For Arnold Devlin, funding for a serious problem like suicide that ends after a five-year period is a major concern:

*One of our greatest concerns is the sustainability of the program; it needs to be linked with some long-term planning and this will be the key to success. If we just think this will be our solution, it will not be effective.*³⁰⁴

14.9.4 Recommendation for Action

The Committee believes it self-evident that long-term suffering will require long-term funding. Aboriginal peoples have endured a lengthy period of alternating indifference and piecemeal attention from the federal and other governments entrusted with their well-being. The Committee is aware of the November 2005 commitments for an Aboriginal Blueprint on health. However, it recognizes that previous announcements such as the \$200 million for

³⁰¹ 31 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/16evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

³⁰² 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

³⁰³ 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13eva-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

³⁰⁴ 20 September 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/27evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

an Aboriginal Health Transition Fund in September 2004 did little to alleviate the health needs of Aboriginal peoples. Discussions relating to the distribution of that money remained “ongoing” some 14 months later. In the meantime, the problems are not getting any better and are probably worsening. There are no data to inform us.

The Committee heard the urgent calls for multi-year, sustained funding appropriate to the magnitude of the problems facing Aboriginal peoples. It has already recommended that the proposed Canadian Mental Health Commission, in consultation with its Aboriginal advisory committee, establish timelines and funding levels to implement wellness and healing programs. It urges prompt movement on this overall strategy and action plan.

The Committee has already recommended the creation of an interdepartmental committee to report to Parliament every two years with a clear inventory of ongoing federal programs and services and the money spent on them. It has also recommended that the federal government work with Aboriginal peoples to identify necessary programs and services combined with appropriate oversight and evaluation criteria.

The Committee further recommends:

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

In a country proud of the rich personal opportunities available to most citizens and the wealth of its human and natural resources, the situation facing Aboriginal people on a daily basis is a shameful blot on the public record. Still, there is reason to hope. The Committee heard that Aboriginal peoples face high levels of mental distress but experience a low incidence of mental disorder. This suggests strongly that many of the current negative outcomes, whether suicide or addiction associated with despair, can be reversed. There is great human potential among Aboriginal peoples, especially given the youthfulness of the population.

In a country proud of the rich personal opportunities available to most citizens and the wealth of its human and natural resources, the situation facing Aboriginal people on a daily basis is a shameful blot on the public record.

There is great human potential among Aboriginal peoples, especially given the youthfulness of the population.

The Committee was encouraged by the repeated testimony that the mental distress facing Aboriginal peoples is preventable and that the effects of decades of fragmented and often negative treatment could be alleviated. It agrees that efforts on the part of governments, communities and individuals can produce positive effects on wellness, especially wellness derived from mental health.

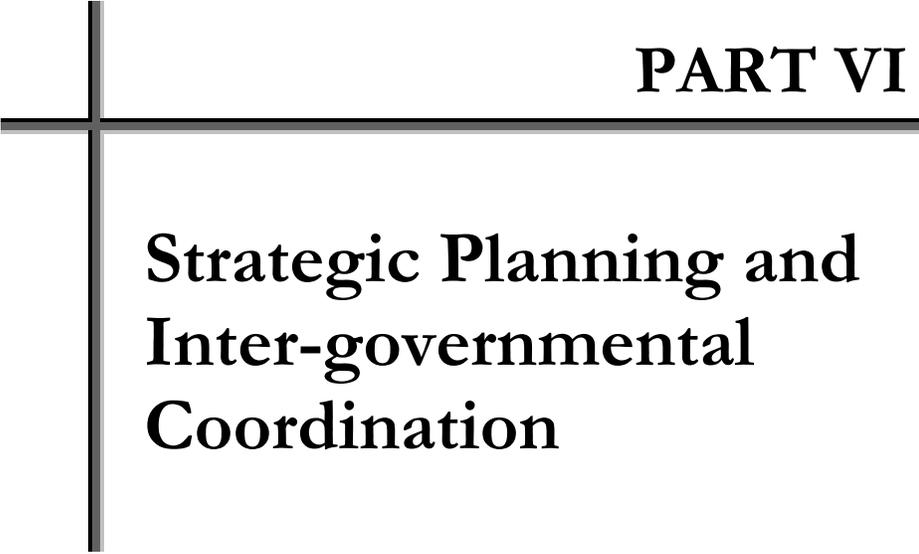
The Committee believes that Canada's long tradition with population health initiatives offers significant promise for improvement in the mental and physical health status of Aboriginal peoples, primarily through practical changes to their social and physical environments. Actions in education, housing, employment and community support can produce significant long-term benefits to Aboriginal peoples.

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The Committee is aware of many initiatives of Aboriginal communities across the country to change their social and physical environments. It also recognizes the ongoing collaborative efforts among all groups — First Nations, Métis, and Inuit. The Committee commends all participants for these shared endeavours.

The Committee strongly supports the development of a national strategy that is holistic, culturally appropriate, community-based, equitable for all Aboriginal peoples, and supported by sustained funding. It calls for the preparation of an action plan based on the determinants of health, one that incorporates specific goals and timelines to achieve measurable beneficial outcomes and that fosters collaboration among all those working to achieve these objectives.

The Committee supports increased, stable, multi-year funding agreements to provide long-term support for long-term goals for a population experiencing serious but preventable problems. It knows that all Canadians are looking for progress on key outcomes that will improve the overall well-being of Aboriginal peoples.



PART VI

**Strategic Planning and
Inter-governmental
Coordination**

CHAPTER 15: MENTAL HEALTH PROMOTION AND MENTAL ILLNESS PREVENTION

15.1 INTRODUCTION

I was trained in a medical model in nursing.... So many of us spend so much time at the end of a fast flowing stream where there is a ton of people drowning at the bottom. We spend time trying to pull them out and figuring out how to keep them from drowning as opposed to moving upstream to figure out what is pushing them in to start with. —Cheryl Van Daalen³⁰⁵

Much of the emphasis in this report is on services for those living with mental illness. But what about preventing mental illness from occurring in the first place?

Mental health promotion emphasizes positive mental health, as opposed to mental illness.

During its hearings, the Committee heard from a number of witnesses who called for greater efforts in mental health promotion and mental illness prevention, two approaches that address factors that may lead to mental illness. By so doing, they reduce both the likelihood of developing mental illness and its severity in the population.

The prevention of mental disorders is a related approach that addresses the risk factors associated with mental illness

Mental health promotion focuses on the foundations of good mental health. Broadly speaking, it emphasizes positive mental health, as opposed to mental illness. It addresses the determinants of mental health — the many personal, social, economic and environmental factors that are thought to contribute to mental health, and to the overall health and well-being of the population. Such factors include healthy childhood development, income and social status, and education.

The prevention of mental illness is a related approach that addresses the risk factors associated with mental illness — such as substance abuse, parental mental illness, and child abuse and neglect — and the protective factors associated with good mental health — such as self-esteem, social support, and a healthy start in life.

While there is a good case to be made for both of these approaches, it is also necessary to develop further evidence linking the various implicated determinants and good mental health. With so many factors at play, it is difficult to be sure of the impact of each determinant individually. Many of them fall outside the fields of health and medical care — an additional complication for researchers. Work is under way to improve the evidence base, but much more needs to be done.

³⁰⁵ 6 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/14mn-e.htm?Language=E&Parl=38&Ses=1&comm_id=47

This chapter provides an overview of the guiding principles and strategies for mental health promotion and the prevention of mental illness, including the need for more and better evidence and for research. It reviews the role of the federal government and makes recommendations for improving mental health promotion and mental illness prevention, particularly with regard to preventing suicide.

15.2 MENTAL HEALTH PROMOTION: THE DETERMINANTS OF MENTAL HEALTH

The central concept behind health promotion is that health is determined by many interacting social, psychological, and biological factors that are amenable to intervention by individuals and society. Mental health promotion employs the same concept. Mental health is not considered merely as the absence of mental illness, but rather as "... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."³⁰⁶

The central concept behind health promotion is that health is determined by many interacting social, psychological, and biological factors that are amenable to intervention by individuals and society.

Determinants of health, according to the World Health Organization (WHO), are "those factors that can enhance or threaten an individual's or a community's health status." They can be matters of individual choice or social, economic, and environmental factors beyond the control of individuals. The determinants of health recognized by Health Canada and the Public Health Agency of Canada are:

- income and social status;
- social support networks;
- education;
- employment/working conditions;
- social environments;
- physical environments;
- personal health practices and coping skills;
- healthy childhood development;
- biology and genetic endowment;
- health services;

The health promotion approach focuses on improving the health of the population by addressing determinants of health that are amenable to change, recognizing that doing so is a long-term process yielding results only in a future more distant than the usual political or even research horizon.

³⁰⁶ World Health Organization. (November 2001) "Mental health: strengthening mental health promotion." Fact Sheet No 229. <http://www.who.int/mediacentre/factsheets/fs220/en/>.

- gender; and
- culture.³⁰⁷

In the Committee's second on-line consultation, almost three-quarters of participants (72%) believed that to improve the mental health of Canadians, we must first address the real causes of most mental illness and addictions — including poverty, poor housing and other social conditions.

The health promotion approach focuses on improving the health of the population by addressing determinants of health that are amenable to change, recognizing that doing so is a long-term process yielding results only in a future more distant than the usual political or even research horizon. The basic action strategies of health promotion were accepted by the international community in 1986 at the First International Conference on Health Promotion. They are set out in the *Ottawa Charter for Health Promotion*:

- build healthy public policy,
- create supportive environments,
- strengthen community action,
- develop personal skills, and
- reorient health services.³⁰⁸

In August 2005, these principles were reiterated at the Sixth Global Conference on Health Promotion, which produced the *Bangkok Charter for Health Promotion in a Globalized World*. This Charter called for political action to implement strategies for health promotion.³⁰⁹

Using these internationally agreed-upon frameworks and guidelines for health promotion generally, comparable frameworks have been developed for mental health promotion. In 2004, the WHO summarized the current thinking on mental health promotion:

1. Promotion of mental health can be achieved by effective public health and social interventions. The scientific evidence base in this area is relatively limited, but evidence at varying levels is available to demonstrate the effectiveness of several programmes and interventions for enhancing mental health of populations.

³⁰⁷ Public Health Agency of Canada. (March 2004) "What determines health?" <http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/index.html#determinants>.

³⁰⁸ Public Health Agency of Canada. (November 1986) "Ottawa Charter for Health Promotion: An International Conference on Health Promotion." <http://www.phac-aspc.gc.ca/ph-sp/phdd/docs/charter/>.

³⁰⁹ World Health Organization. (August 2005) *The Bangkok Charter for Health Promotion in a Globalized World*. http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/index.html.

2. Intersectoral collaboration is the key to effective programmes for mental health promotion. For some collaborative programmes, mental health outcomes are the primary objectives; however, for the majority these may be secondary to other social and economic outcomes but are valuable in their own right.
3. Sustainability of programmes is crucial to their effectiveness. Involvement of all stakeholders, ownership by the community, and continued availability of resources facilitate sustainability of mental health promotion programmes.
4. More scientific research and systematic evaluation of programmes is needed to increase the evidence base as well as to determine the applicability of this evidence base in widely varying cultures and resource settings.³¹⁰

The Committee has commented on health promotion in its earlier reports on the health system. In Volume Five of *The Health of Canadians — The Federal Role*, the Committee wrote “there are potentially enormous benefits to be derived from health and wellness promotion, illness prevention and population health...” Noting that population health strategies should be “long term, national in scope and based on multi-departmental efforts across all jurisdictions,” it said the federal government should continue to provide leadership and devote more resources to them. The Committee also recognized that population health strategies must be adapted to local conditions and their design and implementation must involve local communities.³¹¹

Population health strategies should be “long term, national in scope and based on multi-departmental efforts across all jurisdictions”.

There is evidence of links between determinants of health and the health status of the Canadian population. In Volume Six of *The Health of Canadians*, the Committee advocated continued research in the area but also noted problems with the establishment of cause and effect relationships:

In the first place, the multiplicity of factors that influence health status means that it is extremely difficult to associate cause and effect, especially since the effects of a given intervention are often obvious only after many years. Because political horizons are often of a shorter-term nature, the long timeframe for judging the impact of policy in this area can be a serious disincentive to the elaboration and implementation of population health strategies.

³¹⁰ World Health Organization. (2004) Promoting Mental Health: concepts, emerging evidence, practice: summary report, p. 59. <http://whqlibdoc.who.int/publications/2004/9241591595.pdf>.

³¹¹ Standing Senate Committee on Social Affairs, Science and Technology. (April 2002) *The Health of Canadians — The Federal Role*, Vol. 5, pp. 154-173. <http://www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/soci-e/rep-e/repapr02vol5-e.pdf>.

Furthermore, it is very difficult to coordinate government activity across the diverse factors that influence health status. The structure of most governments does not easily lend itself to inter-ministerial responsibility for tackling complex problems. This difficulty is compounded several times over when various levels of governments, together with many non-governmental players, are taken into account, as they must be if population health strategies are to be truly effective.

Although many difficulties are associated with developing an effective population health approach, the Committee believes it is important for Canada to continue to strive to set an example by exploring innovative ways to turn good theory into sound practice that will contribute to improving the population's health status.³¹²

In its current study on mental health, mental illness and addiction, the Committee has previously stressed the critical importance of combating stigma and discrimination.³¹³ It pointed out that reducing stigma and combating discrimination “requires a multi-pronged effort sustained over a long period of time and includes: ongoing community-based education and action, media campaigns, and forums of exchange between affected individuals and other Canadians to enhance public awareness, and professional awareness campaigns to reduce structural discrimination in the health care system and in the mental health system itself.”³¹⁴ The Committee is also aware that educational campaigns must be complemented with policies that create environments that support change in people's attitudes and behaviours.

The Committee will address the issue of stigma and discrimination in greater detail in the next chapter. Briefly, we believe that a Canadian Mental Health Commission should be established immediately to undertake a systematic and long-term campaign to combat stigma and discrimination (see Chapter 16).

15.3 MENTAL ILLNESS PREVENTION: RISK FACTORS AND PROTECTIVE FACTORS

While mental health promotion addresses the determinants of health with the goal of improving positive mental health, mental illness prevention focuses on reducing risk factors associated with mental illness and enhancing protective factors that

Mental illness prevention focuses on reducing risk factors associated with mental illness and enhancing protective factors that inhibit its onset or shorten its duration.

³¹² Standing Senate Committee on Social Affairs, Science and Technology. (October 2002) *The Health of Canadians — The Federal Role*, Vol. 6, pp. 251-252.

<http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/repoct02vol6-e.pdf>.

³¹³ Standing Senate Committee on Social Affairs, Science and Technology. (November 2004) *Report 3 —Mental Health, Mental Illness and Addiction: Issues and Options for Canada*, Chapter 4, Section 4.1, p. 25.: <http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/soci-e/rep-e/report3/repintnov04vol3-e.pdf>.

³¹⁴ *Ibid.*

inhibit its onset or shorten its duration. A WHO report on the prevention of mental illness provides the following definition:

...mental disorder prevention aims at ‘reducing incidence, prevalence, recurrence of mental disorders, the time spent with symptoms, or the risk condition for a mental illness, preventing or delaying recurrences and also decreasing the impact of illness in the affected person, their families and the society.’³¹⁵

Risk factors are those that increase the probability of the onset, severity, and duration of major health problems. Protective factors are those that improve people’s resistance to risk factors and, therefore, to mental illness.³¹⁶

Mental health promotion and mental illness prevention often form part of the same set of interventions, even though they produce “different but complementary outcomes.”³¹⁷ Some strategies for the prevention of mental illness are similar to those for mental health promotion — such as improved housing and access to education and reduced economic insecurity. Other strategies are more tightly focused — such as coping with parental mental illness, intervening in the workplace, and improving the mental health of elderly populations.³¹⁸

As with mental health promotion, mental illness prevention must be based on an understanding of the causes (etiology). However, as the U.S. Surgeon General has pointed out,

...for most major mental disorders, there is insufficient understanding about etiology and/or there is an inability to alter the known etiology of a particular disorder. While these have stymied the development of prevention interventions, some successful strategies have emerged in the absence of a full understanding of etiology.³¹⁹

Risk factors are those that increase the probability of the onset, severity, and duration of major health problems. Protective factors are those that improve people’s resistance to risk factors and, therefore, to mental disorders.

Some strategies for the prevention of mental disorder are similar to those for mental health promotion — such as improved housing and access to education and reduced economic insecurity. Other strategies are more tightly focused — such as coping with parental mental illness, intervening in the workplace, and improving the mental health of elderly populations.

³¹⁵ World Health Organization. (2004) Prevention of mental disorders: effective interventions and policy options: summary report, p. 17. <http://whqlibdoc.who.int/publications/2004/924159215X.pdf>.

³¹⁶ *Ibid.*, p. 20.

³¹⁷ *Ibid.*, p. 18.

³¹⁸ *Ibid.*, pp. 24-36.

³¹⁹ U.S. Department of Health and Human Services. (1999) Mental Health: A Report of the Surgeon General, Rockville, MD, p. 62. <http://www.surgeongeneral.gov/library/mentalhealth/home.html>.

In developing prevention interventions, the WHO suggests a number of steps to take, including: assessing needs; disseminating best practices; implementing high-quality, evidence-based programs on a large scale; and developing systems for quality assessment and improvement, ensuring those programs' sustainability.³²⁰

15.4 THE NEED FOR EVIDENCE

To be successful, mental health promotion and mental illness prevention interventions must be based on evidence. They require the cooperation of different levels of government, service providers, non-government organizations and affected individuals, and they also require substantial investments — both of which will not be forthcoming unless all stakeholders have a good idea what the probable outcomes of their cooperation and investment will be.

This need for evidence was made clear by the Office of the Auditor General of Canada. After reviewing Health Canada's population health projects, the Auditor General's 2001 report said that "choosing the 'right' priorities at the outset is a critical step toward committing resources to areas that will yield the most benefit in improved population health."³²¹ The Auditor General also expected that priorities would be chosen "on the basis of good, evidence-based information such as surveillance data and evaluations of population health programs."³²²

Mental health promotion and disorder prevention interventions must be based on evidence.

In 2004, the WHO published reports summarizing the evidence relating to the effectiveness of mental health promotion and mental illness prevention interventions. While good evidence was found for some interventions, particularly at the individual level, the WHO considered the economic data on the relative costs and benefits of interventions to be sparse.³²³

It is clear that more data are needed on the effectiveness of mental health promotion and disorder prevention policies and programs.

While the WHO argues that plausible interventions should still be carried out in the absence of outcome evaluations,³²⁴ it is clear that more data are needed on the effectiveness of mental health promotion and mental illness prevention policies and programs.

During the course of the Committee's hearings, some witnesses called on the federal government to gather and disseminate information on mental health promotion and mental

³²⁰ World Health Organization. (2004) Prevention of mental disorders: effective interventions and policy options: summary report, pp. 52-56.

³²¹ Office of the Auditor General of Canada. (2001) Report of the Auditor General of Canada—2001, Chapter 9, "Health Canada: A Proactive Approach to Good Health," p. 1. [http://www.oag-bvg.gc.ca/domino/reports.nsf/html/0109ce.html/\\$file/0109ce.pdf](http://www.oag-bvg.gc.ca/domino/reports.nsf/html/0109ce.html/$file/0109ce.pdf).

³²² *Ibid.*, p. 9.

³²³ World Health Organization. (2004) Promoting Mental Health: concepts, emerging evidence, practice: summary report, p. 47.

³²⁴ *Ibid.*, p. 46.

illness prevention. Ms. Christine Davis, President, Canadian Federation of Mental Health Nurses, testified:

*The federal government must play a role in making the connections between the social determinants of health and the promotion of mental health for children, youth, their families and adults.*³²⁵

Ms. Jennifer Chambers, Coordinator, Empowerment Council, recommended that a national mental health legal advocacy organization serve as a clearinghouse for information needed by advocates across the country.³²⁶

Dr. Mimi Israël, Psychiatrist-in-Chief; Co-director, Clinical Activities Directorate, Douglas Hospital; and Associate Professor, Department of Psychiatry, McGill University, also called for a centralized structure that would, among other things:

- pool data from epidemiological and population studies to measure and monitor population health needs that are changing as our environment changes;
- orient research agendas and research fund allocations;
- translate research findings once they are collected from international health policies aimed at promoting health or preventing illness; and
- centralize the preparation and dissemination of information such as public education and awareness campaigns...³²⁷

Other witnesses called for mental health promotion and mental illness prevention to be part of a national action plan for mental health. As Ms. Nancy Beck, Director, Connections Clubhouse, testified:

*The plan should focus on a population health model, paying attention to prevention, promotion, community care, clinical care, education, research and advocacy. Health Canada's website has incredible resources around the topic of population health. They have been doing research in this area for decades, but I have yet to see that evidence put into operation.*³²⁸

This was echoed by Ms. Annette Osted, Executive Director, College of Registered Psychiatric Nurses of Manitoba:

³²⁵ 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/42362-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

³²⁶ 15 February 2005, <http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/SOCI-E/05evb-e.htm>.

³²⁷ 6 May 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/14ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

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

*We believe that both provincial and national action plans should include a strong mental health promotion plan based on the determinants of mental health. It is evident that mental illness and mental health problems have significant social as well as physical implications. To ensure the sustainability of our health system for future generations, more emphasis must be placed on the health, including the mental health of our population.*³²⁹

15.5 ROLE OF THE FEDERAL GOVERNMENT

Over the years, the federal government has issued several documents that touch on the promotion of mental health and the prevention of mental illness. In 1974, *A New Perspective on the Health of Canadians* was issued by the then Minister of National Health and Welfare, Marc Lalonde. With regard to mental illness, the Lalonde report said:

Much needs to be done ... in informing the public and modifying attitudes towards mental illness. Much needs to be done also in preventing mental illness, identifying positive health factors and promoting them.

The pathological processes at work in our families, our school systems and in our society's value system indicate that programs of prevention directed at large population groups are desperately needed. These programs of prevention would have the advantage of reducing the risks of mental illness while permitting a sharing of responsibility which would abate some of the guilt which individuals find so intolerable.³³⁰

In 1986, the then Minister of National Health and Welfare, Jake Epp, released *Achieving Health for All: A Framework for Health Promotion*. It expanded on the Lalonde report, focusing on the broader social, economic and environmental factors that affect health. It set out three challenges:

- reducing inequities;
- increasing prevention; and
- enhancing coping.³³¹

This was followed in 1988 by *Mental Health for Canadians: Striking a Balance*, in which mental health promotion was put in terms of these three challenges. It suggested a number of actions, including:

³²⁹ 31 May 2005, <http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/SOCI-E/16eva-e.htm>.

³³⁰ National Health and Welfare. (1974) *A New Perspective on the Health of Canadians*, pp. 61-62.

³³¹ Health Canada. (2001 [1986]) *Achieving Health for All: A Framework for Health Promotion*. http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-frame-plan-promotion/index_e.html.

- expanding the body of knowledge concerning the nature and causes of good mental health and prevention of mental illness;
- coordinating policies to ensure a mental health perspective is brought to bear on relevant issues; and
- committing resources to community development and community-based programs and services.³³²

In 1994, the federal, provincial, and territorial Ministers of Health officially endorsed the population health approach. In *Strategies for Population Health: Investing in the Health of Canadians*, they set out three strategic directions for national action:

- Strengthen public understanding of the broad determinants of health, and public support for and involvement in actions to improve the health of the overall population and reduce health status disparities experienced by some groups of Canadians.
- Build understanding about the determinants of health and support for the population health approach among government partners in sectors outside health.
- Develop comprehensive intersectoral population health initiatives for a few key priorities that have the potential to significantly impact population health.³³³

The Integrated Pan-Canadian Healthy Living Strategy represents additional efforts in health promotion. This federal/provincial/territorial initiative aims to improve the overall health of Canadians by addressing preventable risk factors. The federal/provincial/territorial Ministers of Health agreed to work together on the Integrated Pan-Canadian Healthy Living Strategy in 2002.³³⁴ The initial emphasis of the Strategy is on physical activity and healthy eating and their relationship to healthy weight, but it will eventually be expanded to address other priority health issues such as mental health.³³⁵

Addressing preventable risk factors can have a positive impact on the mental health of the population. But this requires a strongly coordinated effort.

Addressing preventable risk factors can have a positive impact on the mental health of the population. But this requires a strongly coordinated effort. The Committee believes that the approach that has been developed under the Integrated Pan-Canadian Healthy Living Strategy should be expanded to include mental health as a priority health issue; it recommends therefore:

³³² National Health and Welfare. (1998) *Mental Health for Canadians: Striking a Balance*.

³³³ Federal/Provincial/Territorial Advisory Committee on Population Health. (1994) *Strategies for Population Health: Investing in the Health of Canadians*, pp. 35-37. http://www.phac-aspc.gc.ca/ph-sp/phdd/pdf/e_strateg.pdf.

³³⁴ Public Health Agency of Canada. (February 2005) "Healthy Living." <http://www.phac-aspc.gc.ca/hl-vs-strat/>.

³³⁵ Coordinating Committee for the Intersectoral Healthy Living Network. (September 2004) *First Meeting Report*, Ottawa, p. 3. http://www.phac-aspc.gc.ca/hl-vs-strat/pdf/meeting_sept04.pdf.

103 **That mental health be included as an immediate priority health issue in the Integrated Pan-Canadian Healthy Living Strategy.**

In its submission to the Committee, the Canadian Psychological Association suggested that a Canadian Mental Health Guide be created. Modelled on Canada's Food Guide, it would

... help reduce stigma and discrimination by recognizing that mental health is part of everyday life, promoting and supporting psychological resilience, enhancing early detection and so on.

The Guide would give concrete advice on topics such as:

- Mentally healthy activities for all ages.
- Early warning signs of psychological stress and what to do about them.
- Normal reactions to life events such as death, tragedy, failure, or loss.
- Ways to improve psychological resilience.
- What is normal in terms of sadness, anxiety etc., and how to recognize when normal reactions might become an illness.³³⁶

The Canadian Psychological Association suggested that a Canadian Mental Health Guide be created modeled on Canada's Food Guide.

The Committee sees merit in this proposal and therefore recommends:

104 **That the Public Health Agency of Canada, in collaboration with other stakeholders, prepare a Mental Health Guide for Canadians and ensure its broad distribution.**

Within the federal government, Health Canada and the Public Health Agency of Canada are both centrally involved in health promotion and illness prevention. Within the Public Health Agency of Canada, the Mental Health Promotion Unit is the focal point of efforts to improve positive mental health and well-being in the Canadian population. The mandate of the Unit is to:

Within the Public Health Agency of Canada, the Mental Health Promotion Unit is the focal point of efforts to improve positive mental health and well-being in the Canadian population.

³³⁶ Canadian Psychological Association. (July 2005) Recommendations to the Standing Senate Committee on Social Affairs, Science and Technology.

... promote and support mental health and reduce the burden of mental health problems and illness, by contributing to:

- the development, synthesis, dissemination and application of knowledge;
- the development, implementation and evaluation of policies, programs and activities designed to promote mental health and address the needs of people with mental health problems or illness.³³⁷

Other federal institutions are also involved in activities related to health promotion. The Institute of Population and Public Health within the Canadian Institutes of Health Research (CIHR) “supports research into the complex interactions (biological, social, cultural, environmental) which determine the health of individuals, communities, and global populations; and into the application of that knowledge to improve the health of both populations and individuals.”³³⁸ The Institute of Neurosciences, Mental Health and Addiction, which supports research on the functioning and disorders of the brain, the spinal cord, the sensory and motor systems, and the mind, constitutes another example.³³⁹

The Committee believes that the federal government needs to increase its capacity to identify national priorities for interventions in mental health promotion and disorder prevention, and to translate these priorities into action.

A further example is the Canadian Institute for Health Information (CIHI), which manages the Canadian Population Health Initiative; its mission is to:

- foster a better understanding of factors that affect the health of individuals and communities, and;
- contribute to developing policies that reduce inequities and improve the health and well-being of Canadians.³⁴⁰

As well, Statistics Canada collects and disseminates statistics on the health of Canadians. It conducts population health surveys, including the Canadian Community Health Survey -

³³⁷ Public Health Agency of Canada. (January 2003) “Mental Health Promotion.” <http://www.phac-aspc.gc.ca/mh-sm/mentalhealth/mhp/index.html>.

³³⁸ Canadian Institutes of Health Research, Institute of Population and Public Health. (May 2003) “What We Do.” <http://www.cihr-irsc.gc.ca/e/12199.html>.

³³⁹ Canadian Institutes of Health Research, Institute of Neurosciences, Mental Health and Addiction. (April 2003) “About INMHA.” <http://www.cihr-irsc.gc.ca/e/8579.html>. See also Chapter 14 for a more detailed discussion of INMHA’s activities.

³⁴⁰ Canadian Institute for Health Information. (March 2004) “About the Canadian Population Health Initiative.” http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=cphi_aboutcphi_e.

Mental Health and Well-being, which was designed to provide national estimates of major mental illness and problems.³⁴¹

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

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

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| 105 | <p>That the federal government commit sufficient resources to enable the Public Health Agency of Canada to take the lead role in identifying national priorities for interventions in the areas of mental health promotion and mental illness prevention and to work, in collaboration with other stakeholders, toward translating these priorities into action.</p> <p>That all mental health promotion and mental illness prevention initiatives contain provisions for monitoring and evaluating their impact.</p> <p>That the Knowledge Exchange Centre (see Chapter 16) work closely with existing bodies such as the Canadian Institute for Health Information, Statistics Canada and the Canadian Institutes of Health Research to collect and disseminate data on evaluations of mental health promotion and mental illness prevention interventions, including campaigns to prevent suicide.</p> <p>That, in this context, the Canadian Mental Health Commission (see Chapter 16) explore the possibility of:</p> <ul style="list-style-type: none">• developing common measures to evaluate mental health promotion and mental illness prevention interventions;• analyzing federal policy initiatives for their probable mental health impact;• identifying clusters of problems and/or at-risk populations that are not currently being addressed. |
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³⁴¹ Statistics Canada. (July 2005) “Canadian Community Health Survey - Mental Health and Well-being.” <http://www.statcan.ca/cgi-bin/imdb/p2SV.pl?Function=getSurvey&SDDS=5015&lang=en&db=IMDB&dbg=f&adm=8&dis=2>.

15.6 SUICIDE PREVENTION

The Committee has identified suicide prevention as another priority. As noted in the Third Interim Report, every year some 3,700 Canadians kill themselves. Although suicidal behaviour is not itself a mental disorder, it is highly correlated with mental illness and addiction — more than 90% of suicide victims have a diagnosable mental illness or substance use disorder.³⁴²

This link between suicide and mental illness was borne out by a recent study of deaths by suicide in New Brunswick. It found that in the large majority of the 102 suicide deaths examined, the “victims had a long-standing trajectory of persistent difficulties in terms of personal development, consisting of an accumulation of personal, family, psychological, psychiatric and social problems.”³⁴³ The study also found that there tended to be “serious addiction problems among the suicide victims.”³⁴⁴ It observed that:

Although suicidal behaviour is not itself a mental disorder, it is highly correlated with mental illness and addiction — more than 90% of suicide victims have a diagnosable mental illness or substance use disorder.

... in general, members of the public can clearly recognize signs of distress and suicidal behaviours. But for many, the next essential step of getting a friend or family member to the appropriate services has not yet become a natural response.³⁴⁵

As this study suggests, suicidal behaviour can be addressed by promotion and prevention interventions. This echoes *A Report on Mental Illnesses in Canada*, which concluded:

Suicidal behaviour can be addressed by promotion and prevention interventions.

Promotion of mental health of the entire Canadian population, reduction of risk factors and early recognition of those at risk of suicidal behaviour play essential roles in decreasing suicide and attempted suicide.³⁴⁶

By making people more aware of the signs of suicidal behaviour, the hope is that those considering suicide will be encouraged to seek help and that it will be available to them, beginning with interventions by family, friends and neighbours.

By making people more aware of the signs of suicidal behaviour, the hope is that those considering suicide will be encouraged to seek help.

³⁴² Standing Senate Committee on Social Affairs, Science and Technology. (November 2004) Report 3 —Mental Health, Mental Illness and Addiction: Issues and Options for Canada, Chapter 4, Section 4.2, p. 27.

³⁴³ Government of New Brunswick, Department of Health and Wellness. (April 2005) Research Project on Deaths by Suicide in New Brunswick between April 2002 and May 2003, p. 7. <http://www.gnb.ca/0055/suicide-e.asp>.

³⁴⁴ *Ibid.*

³⁴⁵ *Ibid.*, p. 8.

³⁴⁶ Health Canada. (2002) *A Report on Mental Illnesses in Canada*, p. 102. <http://www.phac-aspc.gc.ca/publicat/miic-mmacc/>.

Available evidence indicates that when communities work together to increase awareness, the suicide rate can indeed be reduced. One campaign that is often mentioned was conducted by the U.S. Air Force; it “focused on removing the shame associated with mental health problems and on increasing social support, coping skills, and help seeking.” As a result, the number of suicides was reduced by one-third.³⁴⁷

Although many provinces, territories and communities have developed suicide prevention programs,³⁴⁸ Canada does not have a national suicide prevention strategy. Many believe the federal government should work with the provinces, territories, and relevant stakeholders to develop one.³⁴⁹ To quote the Honourable Elvy Robichaud, Minister of Health and Wellness, Province of New Brunswick,

Available evidence indicates that when communities work together to increase awareness, the suicide rate can indeed be reduced.

Another area that would benefit from federal involvement is the issue of suicide prevention and awareness. We have recently released a research study on suicide in New Brunswick. It is clear that this is a complex issue, and is everyone’s responsibility, not just the health and mental health care systems.

Opportunities to provide public information, share knowledge and best practices, and exchange successful programs and initiatives would be beneficial to all jurisdictions and the people they serve.³⁵⁰

The federal government is currently working on an Aboriginal Youth Suicide Prevention Strategy in partnership with the Assembly of First Nations and the Inuit Tapiriit Kanatami, with input from other national Aboriginal organizations, provinces and territories, and federal departments. Mr. Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch, Health Canada, told the Committee that the Strategy had been announced in September 2004; \$65 million was allocated to it over five years. It is designed to support communities in their efforts to prevent youth from becoming suicidal, in particular by reaching out to youths who are at risk of committing suicide and by preventing suicide clusters that are frequently observed in the aftermath of a completed suicide.³⁵¹

Canada does not have a national suicide prevention strategy.

An Aboriginal Youth Suicide Prevention Strategy is designed to support communities in their efforts to prevent youth from becoming suicidal.

³⁴⁷ Knox, K. L., et al. (December 2003) “Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: cohort study.” *British Medical Journal*, Vol. 327, No. 13. <http://bmj.bmjournals.com/cgi/content/full/327/7428/0-b>.

³⁴⁸ Health Canada. (2002) *A Report on Mental Illnesses in Canada*, p. 102.

³⁴⁹ Standing Senate Committee on Social Affairs, Science and Technology. (November 2004) Report 3 —Mental Health, Mental Illness and Addiction: Issues and Options for Canada, Chapter 4, Section 4.2, p. 27.

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

³⁵¹ 20 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/42362-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

The federal government is also involved in research on suicide. In 2003, Health Canada and the CIHR's Institute of Neurosciences, Mental Health and Addiction held a conference to define a research focus related to suicide. The participants identified six major themes: suicide in social and cultural contexts, evidenced-based standards, mental health promotion, multi-dimensional models explaining suicide, spectrum of suicidal behaviours, and a national database for suicide-related research.³⁵²

In October 2004, the Canadian Association for Suicide Prevention, a group of professionals working to reduce the suicide rate,³⁵³ published a *Blueprint for a Canadian National Suicide Prevention Strategy*.³⁵⁴ In his appearance before the Committee, Dr. Paul Links, Professor of Psychiatry, University of Toronto, and President of the Canadian Association for Suicide Prevention, called for federal leadership in developing a national suicide prevention strategy:

*All levels of government, various community agencies and organizations, survivors and clients need to be involved, but it is clear that we must have federal leadership to set out policies, provide resources and set outcome targets, including actual reduction in suicide rates.*³⁵⁵

The *Blueprint for a Canadian National Suicide Prevention Strategy* includes many of the concepts that have been touched on in this chapter. It sets out a number of goals, including:

The Committee believes there is merit in advancing the Canadian Association for Suicide Prevention's initiative aimed at development of a national prevention strategy.

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

The Committee believes there is merit in advancing the Canadian Association for Suicide Prevention's initiative aimed at development of a national prevention strategy. The Committee therefore recommends:

³⁵² Canadian Institutes of Health Research. (February 2003) Press Release, "Canadian suicide experts focus on finding solutions." <http://www.cihr-irsc.gc.ca/e/8106.html>.

³⁵³ Canadian Association for Suicide Prevention. "Purpose and Function." <http://www.thesupportnetwork.com/CASP/purpose.html>.

³⁵⁴ <http://www.suicideprevention.ca/>.

³⁵⁵ 17 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/07ev-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

106	<p>That the federal government support the efforts of the Canadian Association for Suicide Prevention and other organizations working to develop a national suicide prevention strategy.</p> <p>That the Canadian Mental Health Commission (see Chapter 16) work closely with all stakeholders to, among other things:</p> <ul style="list-style-type: none"> • develop consistent standards and protocols for collecting information on suicide deaths, non-fatal attempts and ideation; • increase the study and reporting of risk factors, warning signs and protective factors for individuals, families, communities and society; • support the development of a national suicide research agenda along the lines proposed by the Canadian Institutes of Health Research.
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15.7 CONCLUSION

At the beginning of this chapter, we asked whether it is possible to prevent mental illnesses in the Canadian population by intervening to address their causative factors. The available evidence shows that some interventions aimed at mental health promotion and mental illness prevention are effective in reducing the onset of mental illness and/or its severity and duration. Such interventions should be pursued further and, at the same time, additional evidence of their impact must be collected and assessed. Armed with such evidence, governments and other stakeholders will be more ready to make sustained and long-term investments to help improve the mental well-being of the Canadian population.

CHAPTER 16: NATIONAL MENTAL HEALTH INITIATIVES

16.1 TOWARD A NATIONAL MENTAL HEALTH STRATEGY

From the very beginning of its study of mental health, mental illness and addiction, the Committee has heard the call for a national mental health strategy.³⁵⁶ Many witnesses have stressed the tremendous significance of and need for such a strategy, noting that Canada is alone among the G8 countries not to have one. In fact, it has been five years since the Canadian Alliance on Mental Illness and Mental Health issued *A Call for Action: Building Consensus for a National Action Plan on Mental Illness and Mental Health*.

Canada is alone among the G8 countries not to have a national mental health strategy.

Not having a national strategy symbolizes neglect of mental health issues by government.

While it is important to point out that there is no evidence to suggest that Canada treats people living with mental illness significantly differently than other highly industrialized nations, nevertheless the absence of a national approach to mental health issues represents an important national deficiency. Not having a national strategy symbolizes neglect of mental health issues by government; it also forecloses on a number of very concrete initiatives that would benefit people living with mental illness throughout the country.

16.1.1 What Kind of National Mental Health Strategy Is Needed?

Although many witnesses expressed support for the concept of a national strategy or plan, their views varied on its exact purpose and what it should contain. There were many suggestions relating to the role of the federal government in creating such a strategy.

There is a leadership role for the federal government in the development of a national approach to mental health. The provinces and territories are responsible for delivering health services, including mental health services, to the general population.

Phil Upshall, National Executive Director of the Canadian Alliance on Mental Illness and Mental Health, testified that:

³⁵⁶ As indicated in Chapter 3, the Committee has not been able to devote as much attention to substance use issues as it intended when it embarked on its study of “mental health, mental illness and addiction.” The Committee recognizes that in previous decades, services for the two types of disorder were administered separately; they developed divergent treatment philosophies, used different terminology and constituted different ‘cultures’ that were often in conflict. However, the limitations of this report with respect to substance use issues means that the Committee has been unable to examine fully the similarities and differences in approach in the mental health and substance use fields. Although some examples are drawn from the substance use sector, the main thrust of this chapter concerns the implementation of mental health initiatives at the national level. It would clearly not be appropriate for the Committee to assume that conclusions it has reached after carefully considering the mental health evidence necessarily apply with respect to substance use issues. Some may apply, but the Committee has attempted to avoid any unwarranted assumptions in this regard. There is, however, an important recommendation in this Chapter that the federal government inject an additional \$50 million per year in concurrent disorder programs (see section 16.5.4.1).

*The Canadian Alliance on Mental Illness and Mental Health advocates for an overarching national action plan. ... Our preferred option is a national action plan that is developed by a distinguished blue-ribbon panel including consumers, patients and families, which will advise the policy work of the federal, provincial, and territorial governments. We think that this is an essential element of a national strategy.*³⁵⁷

For its part, the British Columbia Schizophrenia Society suggested that:

*A national mental health plan should be developed to (i) focus on standardized care for the seriously mentally ill; and (ii) monitor outcomes across the country. A Canadian national mental health plan should also establish national standards for education, early intervention and family support that will lead to improvements in treatment and care for Canadians with serious mental illness.*³⁵⁸

Some believed the federal government should take the lead in developing a national plan that would, in the words of Tina Pranger, Mental Health Consultant to Health and Social Services in Prince Edward Island, “provide direction to the provinces and territories in developing, refining and supporting their own mental health plans” and “include national standards for service delivery.”³⁵⁹ Others, such as Jocelyne Green, Executive Director, Stella Burry Community Services in St. John’s, insisted on the need for the federal government to provide “targeted and significant levels of funding for mental health services” that the provinces could access only “if they deliver programs in line with national standards, with no ‘ifs’, ‘ands’ or ‘buts.’”³⁶⁰

From the beginning, the Committee has recognized that mental health, mental illness and addiction issues resonate with every level of government; they affect, to all intents and purposes, the entire population of Canada. Strategies are required at every level — locally, regionally, provincially, federally, and nationally.

The Committee believes it important to make the significant distinction between “national” and “federal,” and to be clear on what a feasible *national* mental health strategy could look like in Canada. Many tend to look on the federal government as the repository of all national efforts and, therefore, call on it to initiate the development of national strategies, independent of the particular sphere of activity.

With mental health reform, however, this approach cannot work. While there is a leadership role for the federal government in the development of a national approach to mental health, this level of government is not responsible for its development and enforcement. The

³⁵⁷ 21 April 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/13evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

³⁵⁸ British Columbia Schizophrenia Society. Brief submitted to the Standing Senate Committee on Social Affairs, Science and Technology.

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

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

Committee believes that, in Canada, any attempt to establish a national approach in health care related areas, including mental health,³⁶¹ must take into account, among other factors, the reality of which organizations actually deliver health-related services and supports and the fiscal capacities of each level of government.

It bears repeating that the provinces and territories are responsible for delivering health services, including mental health services, to the general population. The federal government carries this responsibility only for recognized or registered First Nations and Inuit, Canadian Forces personnel, federal offenders, and a few others that fall under the federal jurisdiction.³⁶²

The federal government's influence on the way health care is delivered is largely exercised through its fiscal capacity, i.e., its spending power. The provinces and territories receive federal grants in exchange for agreeing to respect certain conditions on how they use these transfers. This is how federal legislation such as the *Canada Health Act* works. This basic fact sets limits to the role that the federal government can play in developing a national strategy or a national action plan relating to responsibilities that fall primarily within the jurisdictions of the provinces and territories.

16.1.2 Elements of a “National Strategy”

Does this report contain the elements of a “national strategy”? The answer depends on what one expects a national strategy to contain. Some of the ground-breaking recommendations put forward here by the Committee are, indeed, national in scope. But this report also contains recommendations directed at all levels of government (federal, provincial/territorial, regional and local) as well as at the providers of mental health services and supports. To some extent, at least, the report can serve as the basis upon which a national mental health strategy could be developed.

This report can serve as the basis upon which a national mental health strategy could be developed.

As in its previous reports on the acute care system, the Committee has made recommendations in this report on issues that fall outside the jurisdiction of the federal government. No effective, systematic approach to the delivery of mental health and addiction services could have been made otherwise.

The Committee recognizes that neither the provider groups nor the provincial or territorial governments to which many of the recommendations in this report are addressed are under any obligation to respond to our recommendations. Nevertheless, in our experience with previous health reports, we have found that if recommendations are based on careful consideration of the evidence, they are often received favourably by those to whom they are addressed, jurisdictional boundaries

A mechanism of some sort is needed both to undertake certain critical tasks at a national level and also to maintain a needed national focus on mental health issues.

³⁶¹ It is worth reiterating that, although the range of supports and services that are part of the mental health “system” extend well beyond the sphere of health departments, the services and supports that are the responsibility of health departments are nonetheless clearly critical ones.

³⁶² See Chapter 13, “The Federal Direct Role.”

notwithstanding. The Committee is hopeful, therefore, that its recommendations on mental health, mental illness and addiction will be considered on the basis of their merit by all those to whom they are directed.

An overarching question the Committee believes of particular importance, given the extent to which the mental health sector has been neglected over the decades, is how to maximize the chances of this report's recommendations being acted upon. It has become clear that a mechanism of some sort is needed both to undertake certain critical tasks at a national level and also to maintain a needed national focus on mental health issues.

16.1.3 The Creation of the Canadian Mental Health Commission

The Committee's key recommendation to achieve this objective, a proposal to create a Canadian Mental Health Commission, was made public by the then Minister of Health, the Honourable Ujjal Dosanjh, on 24 November 2005, tabled in the Senate of Canada and released on the Committee's website. Minister Dosanjh announced that the Government of Canada, along with all provincial and territorial Ministers of Health, with the exception of Quebec, had already agreed to the creation of the Commission; their agreement was based on the proposal that the Committee submitted to a meeting of the federal/provincial/territorial Ministers of Health on 23 October 2005. Steven Fletcher, health critic for the Conservative Party in the 38th Parliament, also expressed his support for the establishment of a national Mental Health Commission.

The creation of the Canadian Mental Health Commission heralds a new era in mental health in Canada.

Before presenting an expanded version of this proposal, the Committee would like to comment on the significance of its having already been endorsed and on the role the new Commission will play in the development of a "national" approach to mental health in Canada.

The announcement that a Canadian Mental Health Commission would be created was the culmination of several months of consultations between the Committee and many mental health stakeholders across the country. It was greeted with universal enthusiasm by those concerned with mental health issues in Canada. For example, Dr. John Service, Executive Director of the Canadian Psychological Association, wrote:

It is our belief that the announcement of the Commission was an historic event in Canada. It has the potential to significantly change the way we deal with mental health issues in this country. For the first time, we will have a pan-Canadian forum to examine and draw attention to successes and gaps and to work with governments and stakeholders to improve the lives of Canadians.

It is remarkable that the federal, provincial and territorial governments came together in such a short period of time to agree on a Commission. It is a testament to the fact that governments recognize the extent of the need and the necessity to address the

need as quickly as possible. The governments are to be congratulated for their willingness to collaborate and to come to an agreement.³⁶³

The Canadian Collaborative Mental Health Initiative (CCMHI) also applauded the announcement and pointed to the potential advantages of the Commission's structure:

A real strength of the Commission will be the partnerships it will develop with governments, employers, mental health stakeholder organizations and, in particular, Canadians living with mental illness and their families and caregivers. Advisory committees to the Commission will also play a big role in ensuring the breadth of mental health issues in Canada are well understood and adequately represented.³⁶⁴

For its part, the Canadian Mental Health Association (CMHA) saw the establishment of a Commission on Mental Health and Mental Illness “as a momentous step towards the development and implementation of a strategy to address the mental health needs of all the people of Canada.”³⁶⁵

The Commission will operate at arm's length from government; a majority of its board of directors will come from outside government, as will its Chair.

Dr. Paul Garfinkel, President and CEO of the Centre for Addiction and Mental Health, stressed the importance of the proposal's emphasis on reducing stigma and ending discrimination:

Every day we hear from patients and their families who delayed seeking treatment because they feared the social stigma that a diagnosis of mental illness or addiction would bring. In fact, research shows that two-thirds of affected people never seek treatment. The power of stigma cannot be underestimated, and this commitment by the Federal Government to create a national commission to help 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 — will be welcomed from coast to coast.³⁶⁶

It is no exaggeration to say that the creation of the Canadian Mental Health Commission heralds a new era in mental health in Canada. For the first time, there will be a body that can

³⁶³ Dr. John Service. (28 November 2005) Letter to the Standing Senate Committee on Social Affairs, Science and Technology.

³⁶⁴ CCMHI. (28 November 2005) Press release: Canadian Collaborative Mental Health Initiative applauds the establishment of landmark Commission. http://www.ccmhi.ca/en/news/press/Newsrelease_Nov28.htm.

³⁶⁵ CMHA. (24 November 2005) News release: Commission established to serve country's mental health needs. http://www.cmha.ca/bins/content_page.asp?cid=6-20-21-965-809.

³⁶⁶ CMHA. (24 November 2005) News release: Organizations laud Kirby Committee's proposed new Canadian Mental Health Commission. <http://www.newswire.ca/en/releases/archive/November2005/24/c9611.html>.

help to channel institutional and financial resources at a national level into a sector that has been systematically neglected. The Committee wholeheartedly commends all the Ministers of Health who have signed on to this proposal, as well as the Government of Canada for agreeing to fund the Mental Health Commission.

While the financial resources that are required for the Commission will come from the federal government, its institutional structure also encompasses the other levels of government in addition to non-governmental stakeholders. The Commission will operate at arm's length from government; a majority of its board of directors will come from outside government, as will its Chair (the Mental Health Commissioner of Canada). Thus, no single group, including government, will be able to dominate the Commission's Board of Directors. In this sense, it is very much a "national," as opposed to a "federal," undertaking.

16.1.4 The National Dimension in This Report

The creation of the Mental Health Commission is, in the Committee's view, one of the two key components of what could be called a "national strategy" contained in this report. The second involves the creation of a Mental Health Transition Fund. If agreed to by the federal government, this Fund will permit the transfer of federal funds to the provinces and territories

The Mental Health Transition Fund will permit the transfer of federal funds to the provinces and territories for their use in accelerating the transition to a mental health system predominantly based in the communities in which people with mental illness and addiction live.

for their use in accelerating the transition to a mental health system predominantly based in the communities in which people with mental illness and addiction live. The rationale for this fund is set out in detail in Chapter 5; later in this chapter (see section 16.5) we discuss how large this fund should be and how the money should be raised.

The Committee recognizes that many other recommendations in this report also have a national dimension, despite being directed only at one or another level of government. For example, the investment of an additional \$25 million annually in mental health services research, as recommended in Chapter 11, will have a national impact, although the recommendation is directed solely to the federal government.

The Committee's recommendations, implemented in full, would also move the reform agenda forward in immediate and concrete ways, including by providing funding for transformative change by the provinces and territories.

The recommendations involving the Mental Health Commission and the Mental Health Transition Fund, however, entail the creation of a new institution that brings together not only the different levels of government with responsibility for providing mental health services and supports, but also the people who actually deliver those services as well as the people who benefit from them.

The potential impact of creating of a Mental Health Commission is substantial. Should the Transition Fund also be created, these two entities will represent a truly momentous injection of institutional and financial resources into a sector that has been neglected for decades. The lives of many thousands of Canadians can be improved.

Nevertheless, the Committee hesitates to call this report a national strategy or plan. In other countries, such plans typically specify details about how various services should be provided and who will be responsible, and to whom, for the plan's implementation.³⁶⁷ Important specifics of this kind are not contained in this report; nor would it have been appropriate for the Committee to have included them.

Nonetheless, the national measures that the Committee has recommended in this report lay a firm foundation for an exploration of how a mental health plan could be developed, negotiated, and endorsed by all stakeholders. The Committee's recommendations, implemented in full, would also move the reform agenda forward in immediate and concrete ways, including by providing funding for transformative change by the provinces and territories. In addition, the activities that the Mental Health Commission will undertake on its own (anti-stigma work and establishing a knowledge exchange centre) will significantly alter the landscape for people living with mental illness.

Thus, there is a plan of action in this report with a "national" dimension to the recommendations it contains. The plan is a feasible one tailored to the realities of health care delivery in Canada. The Committee fervently hopes that all stakeholders will agree that its implementation promises a huge advance for people living with mental illness and addiction.

16.2 A PROPOSAL TO ESTABLISH A CANADIAN MENTAL HEALTH COMMISSION

In this section, the Committee's proposal to create a Mental Health Commission is reproduced as tabled in the Senate of Canada on 24 November 2005.³⁶⁸ Section 16.4 contains additional comments on the proposal that the Committee feels it is important to make, including a more detailed discussion of the tasks the Commission will undertake "in-house" (a ten-year anti-stigma campaign and the establishment of a Knowledge Exchange Centre).

16.2.1 Rationale: Why a Commission?

Several factors led the Committee to recommend the creation of a Canadian Mental Health Commission:

No existing organization has a mandate that encompasses, or could be modified to encompass, a majority of the factors set out.

- a) Although the Committee's work and, importantly, recent actions by several provincial governments have begun to focus a long-overdue spotlight on mental health, it remains that the whole complex, pervasive problem of mental illness and addiction in Canadian society continues to be neglected. The Canadian Mental Health Commission will provide a much needed national (*not federal*) focal point that will keep mental health issues in the mainstream

³⁶⁷ See: Standing Senate Committee on Social Affairs, Science and Technology. (November 2004) Report 2 — Mental health, mental illness and addiction: Mental health policies and programs in selected countries. <http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/soci-e/rep-e/report2/repintnov04vol2-e.pdf>.

³⁶⁸ With some minor editing to improve clarity.

of public policy debates in Canada and accelerate the development and implementation of effective solutions to the long-standing problems of this sector.

- b) Those most directly affected are people living with mental illness, their families, friends and employers. But, given that, each year, one in five Canadians will experience a mental illness, virtually all Canadians will be affected, directly or indirectly, by mental illness and/or addiction. Mental illness is truly of 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 both public and private sector businesses and workplaces, mental health problems and substance abuse disorders are responsible for a large proportion of all disability, absenteeism and diminished workplace productivity. The proportion of workplace disability associated with mental illness and substance abuse is rising more rapidly than those associated with other illnesses and has been estimated to cost Canadian companies about \$18 billion a year in recent years.³⁶⁹ The economic as well as the social implications are both obvious and of universal concern.
- e) In every government, whether federal, provincial, territorial or municipal, responsibility for mental health issues is dispersed among several departments and agencies — health, social services, housing, etc. Managing issues that span ministerial/departmental 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 interdepartmental 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 commission. It concluded, however, that no existing organization has a mandate that encompasses, or could be modified to encompass, a majority of the factors set out above. For example, the mandate of the Canadian Centre for Substance Abuse is too narrow to encompass the range of

³⁶⁹ See Chapter 8, “Workplace and Employment.”

mental health issues of concern to this Committee. Moreover, it has no role in changing public attitudes.

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 Canadian Mental Health Commission will *not* have any role in monitoring any government's performance in dealing with mental health and addiction.

It is clear to the Committee that 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 there 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 its various entities such as the First Nations and Inuit Health Branch of Health Canada and Correctional Service Canada.³⁷⁰

The Committee's intention is that the work of the Canadian Mental Health Commission will complement, and not replace, 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 recommends that the Commission "sunset" in ten years.

16.2.2 Guiding Principles of the Canadian Mental Health Commission

The key principles are that the Commission:

- Be an independent, not-for-profit organization at arm's length both from governments and from 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 under way throughout Canada, and avoid duplicating the roles and activities of those currently working in mental health;

Be an independent, not-for-profit organization at arm's length both from governments and from all existing mental health "stakeholder organizations".

³⁷⁰ See Chapter 13, "The Direct Federal Role" for a full discussion of the role of the federal government in delivering mental health services to the client groups for which it has direct responsibility.

- Establish partnerships with governments, employers, mental health research organizations and service providers, other health care organizations, and the spectrum of existing 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.

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

16.2.4 The Commission's Method of Operation

To discharge its mission, the Commission will form collaborative relationships that amount to partnerships with governments, employers, mental health stakeholder organizations, professional associations, research organizations

The Commission will form collaborative relationships that amount to partnerships with governments, employers, mental health stakeholder organizations, professional associations, research organizations and, in particular, those Canadians living with mental illness and their families.

and, in particular, those Canadians living with mental illness and their families. Such relationships will be developed with existing organizations and committees such as the Canadian Institute for Health Information, the Canadian Institutes of Health Research, the Canadian Alliance for Mental Health and Mental Illness and its constituent organizations, the Global Economic Roundtable on Mental Health and Addiction, the Canadian Centre for Substance Abuse, the Public Health Agency of Canada, federal/provincial/territorial

Committees on Mental Health and Substance Use, and other relevant organizations and committees concerned with mental health and addiction.

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

Two advisory committees are obligatory – one composed of representatives of all federal/ provincial/ territorial governments and another of representatives from Canada’s Aboriginal communities

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 all federal/provincial/territorial governments and another of representatives from Canada’s Aboriginal communities.³⁷¹

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.

16.2.5 Activities of the Commission

The Commission’s activities can be divided into six broad categories:

a) Development of a National Mental Health Strategy

- Proposing goals relating to mental health, mental illness and addiction 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 (section 16.2.9 expands on the benefits of the Commission’s being a source of information to governments on such issues);

³⁷¹ See Chapter 13, “The Direct Federal Role,” and Chapter 14, “Aboriginal Peoples of Canada,” for further discussion of the importance of this recommendation.

- Reporting annually to the Federal/Provincial/Territorial Conference of Deputy Ministers of Health and the Deputy Ministers responsible for Social Services (and of other ministries/departments as required);
 - 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) *Synthesizing Relevant Knowledge for Application to the Canadian Context*
- Developing reliable and valid measures, indicators and tools to facilitate monitoring by governments and health authorities of the performance of their mental health systems over time;
 - Developing benchmark capacity requirements for different types of service along the entire spectrum of mental health services.
- c) *Encouraging Research*
- Through the Canadian Institute for Health Information and Statistics Canada, collecting on a regular basis data on the mental health status of Canadians and providing, 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 on how to measure the outcomes of mental health services so that governments can assess the success and effectiveness of their mental health programs.
- d) *Collaborative, Integrative and Networking Activities*
- Supporting consensus-building activities relating to adoption of the best evidence-based clinical and service-delivery practices and system-level approaches;
 - Facilitating the sharing of knowledge across jurisdictions and stakeholder groups regarding effective approaches, developments and innovations;
 - Promoting the integration of primary care services with other forms of service delivery, such as secondary and tertiary treatment services, health promotion and disease prevention programs;
 - 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;
- 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.

e) *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 stigma and 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.

f) *Knowledge Exchange*

- Creating an Internet-based national Knowledge Exchange Centre for the distribution of information about mental health;
- Publishing studies, reports and other documentation on 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.

The Commission is to be advisory and facilitative, *not* operational in nature, apart from its commitment to undertake some project and research work that is consistent with its mission.

The Commission will both contract out projects and undertake work itself 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, apart from its commitment to undertake some project and research work that is consistent with its mission.

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 will reflect the particular characteristics of that jurisdiction.

16.2.6 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).

No nominee can represent a specific organization; each must be widely recognized as reflective of the mental health community at large.

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, may 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 advisory committees (including the federal/provincial/territorial 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 recognized as reflective of 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.

16.2.7 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.

16.2.8 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.

16.2.9 Appendix

Every government faces a myriad of 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 representing “flavour-of-the-month” fads.

Having collected information on 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 there is no mechanism, or at least no easy 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 that 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 must be modified 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 listed above.

16.3 GETTING THE COMMISSION UP AND RUNNING

As noted earlier, on 24 November 2005, Minister Dosanjh announced that the Government of Canada, along with all provincial and territorial Ministers of Health, with the exception of Quebec, had agreed to the creation of the Canadian Mental Health Commission and the Government of Canada agreed to fund the Commission. The Committee believes that it is essential to move forward quickly, and recommends:

- | | |
|------------|---|
| 107 | That a Canadian Mental Health Commission be established and that it become operational by 1 September 2006.
That the guiding principles, mandate, method of operation and activities of the Canadian Mental Health Commission be as specified in sections 16.2.2 to 16.2.5 of this report.
That the composition of the Board of the Commission and its staff be established as set out in sections 16.2.6 and 16.2.7 of this report. |
|------------|---|

That the Government of Canada provide \$17 million per annum to fund the operation and activities of the Commission; of this amount, \$5 million per annum should be dedicated to a national anti-stigma campaign, \$6 million per annum devoted to the creation of the Knowledge Exchange Centre and \$6 million per annum used to cover the operating costs of the Commission.

16.4 FURTHER COMMENTS ON THE PROPOSAL TO CREATE A CANADIAN MENTAL HEALTH COMMISSION

16.4.1 The Nature of “Representation” on the Commission

It is important to make a few additional remarks on the how the Committee envisages choosing the members of the Board of Directors of the Canadian Mental Health Commission and on the nature of their role.

It will be crucial to establish a balance in selecting the 12 non-governmental directors. The Committee believes very strongly that these directors should neither be, nor be seen as, “representatives” of any particular stakeholder group or organization.

The composition of the Board of the Commission was crafted so that it will be able to propose and advocate for innovative policy and educational initiatives that will significantly improve the lives of people living with mental illness across the country. In determining the number of governmental representatives on the Board, both the Committee and the provincial governments with which it has consulted believe it important to include a representative from the three territorial governments, in great measure because of their significant Aboriginal populations. The Committee believes this is one way to ensure that the concerns of Canada’s Aboriginal peoples are at the forefront of the Commission’s activities.

There can be no room on the Board for the kind of “silo” approach that is still all too common in the organization and delivery of mental health services and supports.

It will be crucial to establish a balance in selecting the 12 non-governmental directors. The Committee believes very strongly that these directors should neither be, nor be seen as, “representatives” of any particular stakeholder group or organization.

It will, of course, be essential that the full range of views and expertise from all stakeholder groups be heard, not only via the various advisory committees to be created by the Commission but also at the Board of the Commission itself. However, it is critical that Board members not see themselves, or be seen, as representing any of the narrowly focused interest groups that now constitute integral parts of the current mental health system. There can be no room on the Board for the kind of “silo” approach that is still all too common in the organization and delivery of mental health services and supports. The Board members must be capable of looking at the broad system as a whole and making this the centre of the Board’s concerns.

The key to the success of the Commission will be its ability to take into account a wide cross-section of views and to distill these into a coherent overall program that will improve the lives of people living with mental illness and addiction from coast to coast to coast. The non-governmental members of the Board must be carefully selected to ensure that they bring a diversity of experience to the table but are nonetheless able to look at what needs to be done primarily from the broad perspective of the country as a whole.

There is no doubt that the Board will need in its membership people with knowledge of a variety of mental health constituencies. They must include, first and foremost, people living with mental illness themselves as well as their families. In addition, there must be individuals who understand and have experience of issues confronting people of Aboriginal origin, and the special needs of children and youth, as well as service providers inside and outside the medical professions, and experts in as many areas of mental health as possible.

Additional input from all of these constituencies will also be channelled into the Commission through advisory committees that will be created. In this way, the Committee believes it will be possible for the Commission to have access to the full range of views that will be needed to make sure that its initiatives respond to the needs of Canadians living with mental illness without developing a structure for the Commission that would be so unwieldy as to prevent it from completing its mandate.

16.4.2 Anti-Stigma Campaign

In its first report on mental health, the Committee devoted an entire chapter to the issue of stigma and discrimination.³⁷² Witnesses have consistently told the Committee that a systematic effort to reduce stigma and combat discrimination is essential to improving the situation for people living with mental illness.

During its cross-country hearings, this point was reiterated by Jean-Pierre Galipeault of The Empowerment Connection:

The Committee has included development of a sustained anti-stigma campaign as a key element of the mandate of the Canadian Mental Health Commission.

The Committee believes that there is much to learn from the separate, not-for-profit, private company that was funded by the Australian government called “beyondblue.”

*[A]ll of the efforts in terms of mental health policy development, system reform, consumer and family member involvement will be unattainable without making some efforts to address the issues of stigma and discrimination.*³⁷³

The Committee has included development of a sustained anti-stigma campaign as a key element of the mandate of the Canadian Mental Health Commission. While it will be up to the Commission to work out the details of how this campaign should be undertaken, the Committee believes it is important to summarize the results of its own findings on this issue.

³⁷² Standing Senate Committee on Social Affairs, Science and Technology. (November 2004) Report 1 — Mental health, mental illness and addiction: Overview of policies and programs in Canada, Chapter 3.

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

In its first report, the Committee quoted Professor Heather Stuart from Queen's University, who emphasized the importance of carefully targeting anti-stigma interventions. She told the Committee:

With respect to anti-stigma interventions, how do we stop stigma and discrimination? We are learning from the World Psychiatric Association work that one size does not fit all. It is a waste of time and energy to embark on a large, public education campaign that is designed to improve literacy as an anti-stigma intervention because segments of the population have different views.³⁷⁴

Professor Stuart also noted the connections amongst a number of dimensions to anti-stigma work. She told the Committee that the need to carefully target anti-stigma interventions also pointed to the importance of reaching people at an emotional as well as an intellectual level; it was also important to involve people living with mental illness themselves in these campaigns:

When we talked about targeting things, we were trying to target experiences. We figured out we had to get them at an emotional level. We had to make them aware that their whole system of beliefs was somehow ill-founded. One of the best ways to do that was to construct situations in which people who have a mental illness could meet people who have perhaps never met someone with a mental illness, under controlled and constructive kinds of situations. They would talk about their mental illness. They would convey factual information, but more important, they would convey information at a human level. That is what made the difference.³⁷⁵

This point was reinforced by Tara Marttinen, who told the Committee of her experience of speaking about her own illness:

I have spoken to a diverse range of individuals and groups regarding my illness. Because I am healthy, fairly articulate and approachable, people are generally more receptive to learning about the disease, and I try to shatter those barriers of stigma that people often have. Hence, I strongly recommend implementing a mental health ambassadors program that is not volunteer-based. I believe this should be a paid position and this program would eliminate some of the stigma I think that a lot of people with mental illness have to endure.³⁷⁶

Jean-Pierre Galipeault told the Committee that this kind of effort has to be undertaken at the local level, and sustained over time.

One approach is the old grinding approach, what I am starting to call the "one-block-at-a-time" approach. A couple of years ago a manager of a mental

³⁷⁴ Standing Senate Committee on Social Affairs, Science and Technology. (November 2004) Report 1 — Mental health, mental illness and addiction: Overview of policies and programs in Canada. Chapter 3.

³⁷⁵ *Ibid.*

³⁷⁶ 16 February 2005, http://www.parl.gc.ca/38/1/parlbus/commbus/senate/Com-e/soci-e/06evb-e.htm?Language=E&Parl=38&Ses=1&comm_id=47.

health program in downtown Dartmouth asked me how can we make sure that consumers are viewed as full citizens. I think part of the answer is those of us who are involved in this [have] a responsibility to assist in this regard. I told her to take a one-block or a two-block radius of you're the program location and hold a town hall meeting and have consumers present and talk to the citizens in that area. I told her to start knocking on doors, dropping off flyers, inviting people out and letting them know how consumers contribute to the economic well-being of that two-block community and how they contribute to the cultural mosaic of that community. You work those two blocks for a period of months or a year and then you spread out to two more blocks. I think it is a long, slow approach, but I think it is part of the solution.³⁷⁷

Several witnesses also highlighted the importance of making resources available across the country to support this kind of campaign. The Honourable Elvy Robichaud, Minister of Health and Wellness in New Brunswick, told the Committee:

Stigma is more difficult to address, and is not open to legislative protection as is discrimination under the human rights legislation. In this area, the federal government could play a major leadership role. Anti-stigma and social marketing campaigns are costly and often beyond the fiscal resources available in our province, or if we did it on our own. It might be a whole lot better if all jurisdictions would get into the act and have something that is at least essentially the same. Usually we can adapt to most any Canadian jurisdiction. Further, this is an area in which the federal government has demonstrated competence and leadership — for instance, on the tobacco campaign — and one in which federal initiatives would be beneficial to all provinces and territories.³⁷⁸

Reid Burke, Executive Director, Canadian Mental Health Association of Prince Edward Island, emphasized both the need to sustain anti-stigma campaigns over time and the need to focus on the potential for recovery:

Social marketing and changing attitudes is the way to go. It is not going to happen with one campaign. ParticipAction took 10 or 15 years and now everybody well understands how important that is. If we want to call it “mental fitness” or “mental wellness,” there needs to be a concerted effort in this country to put money into social marketing that normalizes mental health. I do not think that will take away from the devastating effects of the illness, but we need to promote hope, as well as recovery and resilience.³⁷⁹

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

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

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

The Committee was very impressed by initiatives undertaken by the Australian government to educate people about the realities of mental illness and to combat stigma. In particular, the Committee believes that there is much to learn from the separate, not-for-profit, private company that was funded by the Australian government called “*beyondblue*.” The company was established in October 2000 with the objective of promoting a better understanding of depression. It works in partnership with health services, schools, workplaces, universities, media and community organizations, as well as with people living with depression, and thus brings together both expertise in depression and personal experience of the problem.³⁸⁰

In its plan for the years 2005-2010, *beyondblue* notes that:

- As an independent national body, *beyondblue* can reach beyond government politics and policies into states, territories and local communities and across regional and rural Australia. *beyondblue* will establish new and expand existing programs to meet emerging national priorities for prevention, treatment and awareness of depression, anxiety and related substance use disorders.
- *beyondblue*'s collective national strengths are greater than an individual state-based focus on depression. It is cost-effective for all state and territory governments to conduct their promotion, prevention and early intervention strategies for depression and related disorders in partnership with *beyondblue*. The return on investment through delivery of national programs and website provides outcomes that are greater in value than the individual contributions made by state and territory governments.
- States and territories already benefit from the greater understanding of depression generated by *beyondblue*'s national awareness programs, positive media and community profile, and the *beyondblue* website with its series of clinical fact sheets; interactive on-line depression self-assessment; media centre and supporting links.³⁸¹

The various initiatives undertaken in Australia had helped improve “mental health literacy in the Australian population by about 10 percentage points since 1996.”

Mr. Dermot Casey, Assistant Secretary, Health and Priorities and Suicide Prevention, for the Department of Health and Ageing, Government of Australia, told the Committee that the various initiatives undertaken in Australia had helped improve “mental health literacy in the Australian population by about 10 percentage points since 1996.” He also told the Committee that:

our hospital contact data and our health service contact data show that there is a greater proportion of the population seeking care than was the case when we

³⁸⁰ Standing Senate Committee on Social Affairs, Science and Technology. (November 2004) Report 2 — Mental health, mental illness and addiction: Mental health policies and programs in selected countries, Chapter 1, p. 17. <http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/soci-e/rep-e/report2/repintnov04vol2-e.pdf>.

³⁸¹ *beyondblue*: The Way Forward 2005 — 2010. http://www.beyondblue.org.au/index.aspx?link_id=2.18&tmp=FileDownload&fid=88.

*did our epidemiology study. We would conclude from that that they are now at least more prepared to seek treatment...*³⁸²

A recent study of the impact of *beyondblue* confirmed Mr. Casey's assessment, and noted that:

The data are consistent with *beyondblue* having had a positive effect on some beliefs about depression treatment, most notably counselling and medication, and about the value of help-seeking in general. These findings suggest that national awareness campaigns may be effective in improving community mental health knowledge. The data also demonstrate the potential value of population monitoring of mental health literacy.³⁸³

There are thus six points that stand out in with regard to building an anti-stigma campaign in Canada. The evidence strongly suggests that, to be successful, an anti-stigma campaign must:

1. Be carefully targeted to specific audiences;
2. Be sustained over a substantial period of time;
3. Both educate people about the reality of mental illness and engage them at an emotional level;
4. Involve people living with mental illness as spokespeople;
5. Focus on the potential for recovery and highlight the positive contributions made to local communities by people living with mental illness;
6. Deploy national resources that can be adapted to regional and local circumstances.

The Committee believes that these lessons should guide the Mental Health Commission in the design and implementation of the anti-stigma campaign with which it has been charged.

These lessons should guide the Mental Health Commission in the design and implementation of the anti-stigma campaign with which it has been charged.

16.4.3 Knowledge Exchange Centre

As outlined above, the second major task that the Canadian Mental Health Commission will undertake is the creation of a Knowledge Exchange Centre. Many witnesses pointed to the need for such a centre.

³⁸² Standing Senate Committee on Social Affairs, Science and Technology. (November 2004) Report 2 — Mental health, mental illness and addiction: Mental health policies and programs in selected countries, Chapter 1, p. 17. <http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/soci-e/rep-e/report2/repintnov04vol2-e.pdf>.

³⁸³ Jorm, A., Christensen, H., and Griffiths, K. (2005) The impact of *beyondblue*: the national depression initiative on the Australian public's recognition of depression and beliefs about treatments. *Australian and New Zealand Journal of Psychiatry*, Vol. 39, p. 253.

Moreover, in October 2005, the Committee received a detailed proposal from three distinguished academics that contains recommendations that align very closely with the Committee's intentions. The following observations draw on this submission by Goering, Goldner and Lesage³⁸⁴ and expand on the description contained in the Committee's proposal to create the Commission reproduced above (see section 16.2.1).

The authors call for the creation of a "Canadian Mental Health Services Knowledge Translation Network" that is very similar to the Knowledge Exchange Centre and related functions of the Commission in the Committee's proposal. The network would be

"A national, dedicated focus for carrying out the mental health services knowledge translation function, currently does not exist."

a dedicated national, expert resource to facilitate mental health services knowledge translation, including the use of research syntheses and best practices across the country regarding the organization and delivery of mental health prevention, treatment, rehabilitation and support services. ...The Network would facilitate the exchange of the best available knowledge between mental health services knowledge producers and users across Canada. It would facilitate the translation of mental health services research into "on the ground" policies and practices.³⁸⁵

Based on a scan of several organizations in Canada (including the Canadian Centre on Substance Abuse, the Canadian Institute for Health Information, and the Canadian Institutes of Health Research) the authors found that "while several individuals and organizations across Canada are engaged in mental health services knowledge translation activities in a variety of capacities, this function is typically not their primary focus," and that "a national, dedicated focus for carrying out the mental health services knowledge translation function, currently does not exist."³⁸⁶

The Committee agrees that these functions can best be carried out by a "neutral source, one that is not affiliated or driven by any current mandate or particular stakeholder interests, other than knowledge translation."³⁸⁷ Such an organization would produce "research syntheses, national and best practice reports regarding the organization and delivery of mental health prevention, treatment, and rehabilitation and support services"³⁸⁸ targeted at governments, providers, and people living with mental illness and their families.

³⁸⁴ Goering, P., Goldner E., and Lesage, A. (October 2005) Proposal submitted to the Committee by Research in Addictions and Mental Health Policy Services, Canadian Mental Health Services Knowledge Translation Network.

³⁸⁵ *Ibid.*, p. 4.

³⁸⁶ *Ibid.*, p. 8.

³⁸⁷ *Ibid.*

³⁸⁸ *Ibid.*, p. 3.

The authors point out that:

Effective knowledge translation also requires expertise in determining what constitutes quality knowledge and the ability to develop and apply optimal methodologies for effective knowledge transfer and utilization. Expertise on mental health service and system issues is vital given the particularly difficult and complex issues with which this sector must grapple — stigma and discrimination, and a low public policy profile.³⁸⁹

This would entail both “pushing” research results out to users and facilitating the ability of people to “pull” material from the organization’s database, as well as allowing exchanges between both “pushers” and “pullers.” Thus it would be possible to do the following:

“Push” research findings out to users:

- Translation of available high-quality, relevant mental health prevention and services research;
- New mental health services research syntheses/summaries;
- New national reports on the state of the mental health system;
- New national reports on the status of mental health of Canadians;
- New best-practice reports on mental health services; and
- Toolkits that provide means of evaluating the fidelity and outcomes of programs.

Facilitate user “pull”:

- Database of existing knowledge syntheses, national and best-practice reports;
- Mental health services knowledge needs assessments; and
- Capacity development through the training and education of knowledge users — i.e., federal, provincial and territorial planners, decision-makers and leaders of service providers and community organizations, as well as advocates for people living with mental illness.

Facilitate exchange between “pushers” and “pullers”:

- Provide a rapid response consultation service on priority areas, based on the best available knowledge;
- Educational symposia, seminars, and workshops that facilitate knowledge exchange; and

³⁸⁹ *Ibid.*, p. 9.

- A comprehensive Internet-based knowledge exchange portal.³⁹⁰

The Committee also agrees with the authors that the Knowledge Exchange Centre should “collaborate with existing organizations within and outside of the federal and provincial/territorial governments to avoid duplication and ensure that its efforts add value.”³⁹¹

The Committee believes that the Canadian Mental Health Commission should draw on these observations as it establishes the Knowledge Exchange Centre.

The authors also rightly point out that there are many tasks that the Centre should *not* undertake, including:

- Funding and undertaking specific research projects;
- Recreating existing knowledge, data, or information;
- Recreating existing knowledge transfer tools and resources (e.g., Canadian Health Services Research Foundation);
- Maintaining research databases;
- Providing 1-800 service for consumers seeking to access mental health services;
- Directing consumer/provider/system advocacy; and
- Implementing knowledge (i.e., policy or service implementation at the provincial, regional, local and individual levels).³⁹²

The Committee believes that the Canadian Mental Health Commission should draw on these observations as it establishes the Knowledge Exchange Centre.

16.5 THE NEED FOR FEDERAL INVESTMENT IN MENTAL HEALTH

As discussed in Chapter 5, a number of significant benefits would be realized by accelerating the transition to a community-based system of mental health care. Research reviewed in that chapter shows that community care leads to better mental health outcomes,³⁹³ and that treatment within the community environment can improve access to care while making the mental health care system more sustainable. It also enables greater participation in the organization and running of the system by people living with mental illness and their families, community organizations, and voluntary health organizations.

During the transition period the old system must be sustained until the new one can take its place.

³⁹⁰ *Ibid.*, p. 11.

³⁹¹ *Ibid.*, p. 5.

³⁹² *Ibid.*, p. 12.

³⁹³ See Chapter 5, “Toward a Transformed Delivery System.”

Most importantly, the provision of mental health services and supports in the community fosters recovery by giving people living with mental illness more autonomy and independence. They gain the ability to live in their communities with minimal intervention by formal services; to the greatest extent possible, they make their own decisions.

In order to complete this transformation of the mental health care system from an institutionally based system to one that is predominantly based in the community, a targeted investment by the federal government is needed in the form of a Mental Health Transition Fund.

Despite these benefits, we saw in Chapter 5 that the movement toward a community-based system has not fully taken root. In many cases, deinstitutionalization has been undertaken without the necessary community supports being in place. The result has been that far too many people living with mental illness have ended up in prisons and homeless shelters — indeed, prisons and shelters have become the asylums of the 21st century. Alternatively, families have been burdened with responsibility for care.

The provision of mental health services and supports in the community fosters recovery by giving people living with mental illness more autonomy and independence. They gain the ability to live in their communities with minimal intervention by formal services; to the greatest extent possible, they make their own decisions.

Far too many people living with mental illness have ended up in prisons and homeless shelters — indeed, prisons and shelters have become the asylums of the 21st century. Alternatively, families have been burdened with responsibility for care.

Part of the problem has been that it has proven difficult to fund the costs of transition from institutional to community care. During the transition period the old system must be sustained until the new one can take its place. As explained in Chapter 5, the Committee believes that in order to complete this transformation of the mental health care system from an institutionally based system to one that is predominantly based in the community, a targeted investment by the federal government is needed in the form of a Mental Health Transition Fund.

The Mental Health Transition Fund (MHTF) should have two main components: a Basket of Community Services (BCS) to assist provinces to provide services and supports in communities to people living with mental illness, and a Mental Health Housing Initiative (MHHI) to provide federal funds for the construction of new affordable housing units, as well as for rent supplements

Both of these initiatives would be subject to the same ten-year sunset provision as the Canadian Mental Health Commission.

In the Committee's view, this Mental Health Transition Fund (MHTF) should have two main components: a Basket of Community Services (BCS) to assist provinces to provide services and supports in communities to people living with mental illness, and a Mental Health Housing Initiative (MHHI) to provide federal funds for the construction of new affordable housing units, as well as for rent supplements so that people living with a mental illness, who could not otherwise afford to do so, can rent suitable accommodation at market rates.

The costs of supporting and treating people in the community are roughly equivalent to the costs of the old institution-heavy system.

The MHHI, it has a specific target — the elimination of discrimination in the provision of affordable housing to people living with mental illness.

Both of these initiatives would be subject to the same ten-year sunset provision as the Canadian Mental Health Commission; neither would entail new open-ended funding obligations on the part of the federal government.

With regard to the BCS, research shows that the costs of supporting and treating people in the community are roughly equivalent to the costs of the old institution-heavy system.³⁹⁴ This means that once a new “steady state” has been achieved, it will be sustainable with the same level of provincial government spending as was devoted to the institutional system it will have replaced. This will allow withdrawal of support by the federal government after a transition period. With regard to the MHHI, it has a specific target — the elimination of discrimination in the provision of affordable housing to people living with mental illness; it too will end after ten years.

The Mental Health Transition Fund is a genuine *transition* fund. It is designed solely to cover the costs associated with the shift from one way of organizing mental health services to another.

As noted in Chapter 5, the Committee has been very careful in crafting its recommendations to ensure that the Mental Health Transition Fund is a genuine *transition* fund. It is designed solely to cover the costs associated with the shift from one way of organizing mental health services to another that will cost the same once the transition is complete. In this, it is unlike many other federal initiatives that have also been called “transition funds,” such as the Primary Care Transition Fund. Too often, such federal initiatives have entailed the creation of new programs that must either be supported by new provincial money or disbanded once the federal funding that sparked their creation has come to an end. Such initiatives place subsequent ongoing obligations on provincial and territorial governments to fund them.

The Committee believes strongly that the federal government must provide the funds needed to accelerate the transformation of the mental health care system. Therefore, the Committee recommended in Chapter 5:

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- 108 **That the Government of Canada create a Mental Health Transition Fund in order to help accelerate the transition to a system in which the delivery of mental health services and supports is based predominantly in the community.**
- That this Fund be made available to the provinces and territories on a per capita basis, and that the Fund be administered by the Canadian Mental Health Commission that has been agreed to by all Ministers of Health (with the exception of Quebec).**
- That the provinces and territories be eligible to receive funding from the Mental Health Transition Fund for a Basket of Community Services, as long as these projects:**

³⁹⁴ *Ibid.*

- **Would not otherwise have been funded; that is, these projects would represent an increase in provincial or territorial spending on mental health services that is over and above existing spending on services and supports plus an increment equal to the annual percentage increase in overall spending on health;**
- **Contribute to the transition towards a system in which the delivery of mental health services and supports is based predominantly in the community.**

That, as part of the Mental Health Transition Fund, the Government of Canada create a Mental Health Housing Initiative that will provide funds both for the development of new affordable housing units and for rent supplement programs that subsidize people living with mental illness who would otherwise not be able to rent vacant accommodation at current market rates.

That, in managing the housing portion of the Mental Health Transition Fund, the Canadian Mental Health Commission should work closely with the Canada Mortgage and Housing Corporation.

The requirement that Transition Fund monies be incremental to current provincial/territorial spending on mental health should *not* act as a disincentive to improved productivity in delivering mental health supports and services. The availability of new funds should not deter anyone in the mental health system from actively working to use all public funds as efficiently as possible. The Committee believes it important that savings derived from productivity increases be available to health departments to invest throughout the health care system and not exclusively on mental health and addictions.

16.5.1 Managing the Transition Fund

The Committee believes strongly that the Canadian Mental Health Commission should manage the Mental Health Transition Fund. The Commission will be a truly national body with expertise like none other in mental health care. It will be able to consult all stakeholders on how best to ensure that the fund is used effectively, and it will be able to collaborate with the provinces and territories on the design, administration and implementation of the fund.

The Canadian Mental Health Commission should manage the Mental Health Transition Fund.

As discussed in Chapter 5, the Commission would not direct how the monies from the Basket of Community Services portion of the fund should be utilized, other than to ensure that they are used to support the transition to community-based services (such as Assertive Community Treatment Teams, Home Withdrawal Management Programs, Intensive Case Management and Crisis Intervention Services) and to verify that federal money is used to increase the amount that provinces and territories would otherwise have spent on mental health services and supports. The Committee has deliberately left open which specific

programs would be covered under the Basket of Community Services. In other words, it has not attempted to define a comprehensive list of services and supports that would be eligible to receive money from the Mental Health Transition Fund.

In Chapter 5, the Committee explained the many reasons for adopting such a non-prescriptive approach. In part, it is based on the recognition that the Committee does not have the necessary expertise to undertake such a task.

The fund should be distributed to the provinces and territories on the basis of population.

There is also the reality of regional and local diversity of circumstance — needs are so varied, resources so differently distributed that it would not be appropriate for any national body to attempt to specify in detail which services and supports deserve to be funded. Any examples that are given in this report are just that — examples of the kinds of services and supports the Committee believes should qualify for Transition Fund support.

The Committee also believes that the fund should be distributed to the provinces and territories on the basis of population. However, access to family and community-based health care services is a particular challenge in the territories, where the distribution of small populations across vast and remote regions poses huge obstacles to community-based delivery of mental health services.

Territorial governments should receive additional funding to assist the provision of community-based mental health care services to remote populations.

The federal government recognized these difficulties at the September 2004 First Ministers meeting on health care by creating a Territorial Health Access Fund (\$150 million over five years). The Committee also acknowledges the particular circumstances and needs of the territories. It believes that they should receive additional funding to assist the provision of community-based mental health care services to remote populations. The Committee therefore recommends:

In the case of Prince Edward Island, careful consideration should be given to the possibility of adjusting the per capita funding level.

109

That the territories receive additional funding from the federal government, over and above their per capita allocation from the Mental Health Transition Fund, in order to assist them in addressing the needs of remote, isolated and non-urban communities.

The Committee also recognizes that similar concerns have been raised concerning per capita funding by some of the smaller provinces. The Committee believes that in the case of Prince Edward Island, careful consideration should be given to the possibility of adjusting the per capita funding level in order to ensure that sufficient funds are transferred to that province to enable it to complete the transition to a community-based mental health delivery system.

As noted in Chapter 5, the federal government, stakeholders, and Canadians in general are entitled to know that money from the Mental Health Transition Fund is: (a) spent on community-based mental health projects; and (b) used to increase the total amount each jurisdiction is spending on enhancing mental health and treating mental illness. The goal is

that the Transition Fund be used to support transformation of the mental health care system, not as a substitute for existing provincial or territorial spending.

The Committee realizes that provinces and territories are not in favour of having to report to the federal government or a national organization on how they manage their health care spending. Nonetheless, the Committee strongly believes that there should be some form of accountability for the use of money from the Fund. Therefore the Committee recommends:

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| 110 | <p>That the use of the monies from the Mental Health Transition Fund should be subjected to an external audit, to be performed by provincial auditors general in order to ensure that the monies are spent in a manner consistent with the two objectives of the Transition Fund, namely:</p> <ul style="list-style-type: none">(a) to fund community based mental health services and supports; and(b) to increase the total amount each jurisdiction spends on enhancing mental health and treating mental illness. |
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Subjecting the use of money from the Transition Fund to an external audit will also help to ensure that these funds are effectively segregated from the rest of the health care system. By making it easier for provincial and territorial health ministers and deputy ministers to resist internal pressure from other spending demands of their government, that segregation would help to prevent money from the Mental Health Transition Fund from simply disappearing into the acute care system.

Segregation would help to prevent money from the Mental Health Transition Fund from simply disappearing into the acute care system.

16.5.2 Estimating the Overall Cost of the Basket of Community Services

There are currently no reliable data on what it would cost to complete the transformation of the mental health care system from an institutional base to one that is predominantly based in the community. An accurate assessment would require a needs-based analysis not just in each province and territory but within the regions of each jurisdiction, given that the services available and the unmet needs vary greatly across the country and from community to community.

The Committee believes that ten years is a realistic time frame for transition, although it recognizes that it may not be possible to put in place at once all the programs that are needed. Instead, it may be necessary to begin slowly and increase the flow of funds over time.

The mental health care “system” is diverse and fragmented; most services and supports operate independently of one another. It is thus very difficult to assess even approximately the needs and the capacity shortfalls in the current system. Consequently, the Committee has relied upon the work of others to establish a reasonable estimate of the size of an effective transition fund.

In 2000, the Ontario Minister of Health and Long-Term Care established nine regional task forces to develop recommendations for regional and local improvements to mental health services across Ontario; these included restructuring the psychiatric hospital system, community reinvestments and the implementation of mental health reform.³⁹⁵ The Toronto-Peel Mental Health Implementation Task Force, like the other regional task forces, made a wide range of recommendations affecting the full spectrum of mental health care services.³⁹⁶ It also provided an overall costing estimate to transform the mental health care system in that region.³⁹⁷

The Committee's estimate of the overall cost of transforming the mental health system is based on the work of this task force. Rather than attempt to cost out each and every recommendation, the Toronto-Peel Task Force provided an overall, "order-of-magnitude" estimate of the increases required in the base funding for mental health care services in its region. It concluded that, to achieve an adequate transformation, the region's mental health system required an investment of approximately \$245 million over five years.

The report by the Toronto-Peel Task Force is one of the few detailed, systematic attempts to examine the needs of the mental health care system in Canada and provide an estimate of the costs of transforming that system. While the Committee realizes that the area studied is largely urban, it combines a fairly well serviced area, Toronto, with one of the most poorly serviced areas in Ontario from a mental health service and support perspective, Peel.³⁹⁸

Furthermore, the Toronto-Peel region incorporates a high degree of socio-economic diversity. The Task Force had to balance the gaps and capacity needs of each part of the region. Similarly, it would be up to each province and territory to determine where services are most needed and where additional resources would be most effectively allocated. The Committee believes that the costing estimate of the Toronto-Peel Task Force is a useful base from which to calculate what the needs of the mental health care system might be in Canada generally.

In order to determine the overall size of the transition fund for all the provinces and territories, the Committee extrapolated on the basis of population from the Toronto-Peel region to the rest of Canada. In 2001, when the last census was conducted, Toronto-Peel constituted 30.42% of the population of Ontario; Ontario constituted 38.02% of the population of Canada. By extrapolation, the total required for Canada would be \$2.148 billion.

The Toronto-Peel Task Force requested that the recommended increase in funding be allocated over five years. The Committee believes, for two reasons, that it would be preferable to spread the allocation to the Mental Health Transition Fund over ten years:

³⁹⁵ Ontario Ministry of Health and Long-Term Care. (1999) *Making it Happen*.

³⁹⁶ Toronto-Peel Mental Health Implementation Task Force. (December 2002) *The Time Has Come: Make it Happen — A mental health action plan for Toronto-Peel*.

³⁹⁷ Many regions had difficulty accurately determining the level of current funding, and what information they did collect indicated a wide regional disparity of per capita funding levels for mental health care within the province of Ontario.

³⁹⁸ Toronto-Peel Mental Health Implementation Task Force. (December 2002) *The Time Has Come: Make it Happen — A mental health action plan for Toronto-Peel*, p. 314.

- First, given the human resource and supportive housing shortage facing the mental health sector, the Committee does not believe that the system could effectively absorb the full transition funding in five years.
- Second, it is unreasonable to expect the federal government to be able to afford to close the service funding gap in a period as short as five years.

The Committee believes that ten years is a realistic time frame for transition, although it recognizes that it may not be possible to put in place at once all the programs that are needed. Instead, it may be necessary to begin slowly and increase the flow of funds over time. Therefore, the Committee recommends:

111	That the Basket of Community Services component of the Mental Health Transition Fund average \$215 million per year over a ten year period, for a total of \$2.15 billion.
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This is a lot of money, but the total pales in comparison to the estimated \$2.7 billion the province of Ontario alone spends on mental health care each year³⁹⁹ or to the \$14.4 billion that mental illness and substance use problems cost Canada in 1998.⁴⁰⁰

16.5.3 Mental Health Housing Initiative

As discussed in greater detail in Chapter 5, one of the biggest problems facing people with mental illness is the lack of affordable housing. Because people with mental illness often have little or no income, they are often forced to live in neighbourhoods characterized by high crime rates, drugs and violence. Among the homeless, it has been estimated that between 30% and 40% have mental health problems.⁴⁰¹

Among the homeless, it has been estimated that between 30% and 40% have mental health problems.

The percentage of Canadians who are living with mental illness who need access to such housing is almost double the percentage of people in the general population whose housing needs are not being met. This constitutes discrimination against people living with mental illness.

According to data provided by the Canada Housing and Mortgage Corporation, 15% of the Canadian population as a whole is in need of housing that is adequate, suitable, and affordable.⁴⁰² At the same time, the housing situation confronting people living with mental

³⁹⁹ Provincial Forum of Mental Health Implementation Task Forces. (2002) Final Report—The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario, p. 62.

⁴⁰⁰ The \$14.4 billion is the total of \$6.3 billion in direct health care costs and an estimated \$8.1 billion in indirect costs related to premature death and productivity loss. See: Standing Senate Committee on Social Affairs, Science and Technology. (November 2004) Report 1 — Mental health, mental illness and addiction: Overview of policies and programs in Canada, p. 101.

⁴⁰¹ See Chapter 5, “Toward a Transformed Delivery System.”

⁴⁰² According to the Canada Housing and Mortgage Corporation, “core housing need refers to households which are unable to afford shelter that meets adequacy, suitability, and affordability

illness is considerably worse; 27% (approximately 140,000) are in need of adequate, suitable, and affordable housing.⁴⁰³ In other words, the percentage of Canadians who are living with mental illness who need access to such housing is almost double the percentage of people in the general population whose housing needs are not being met. The Committee believes that this constitutes discrimination against people living with mental illness.

According to the Canadian Mental Health Association, between 1980 and 2000, the number of affordable housing units created by the Government of Canada dropped from 24,000 to 940.⁴⁰⁴ In many communities, adequate and affordable housing is beyond the means of people who rely on publiclyfunded income support. For example, in British Columbia, people on disability benefits or social assistance receive \$325 for shelter costs per month, yet average market rents in Metropolitan Vancouver are over \$600 per month; even run-down single-room-occupancy hotel rooms cost \$350 a month on average.

More affordable housing units are required; more assistance is needed so that people can afford to rent existing apartments at market rates; and more supportive services are needed so that people living with a mental illness can live in their communities.

The Committee concluded unequivocally in Chapter 5 that: more affordable housing units are required; more assistance is needed so that people can afford to rent existing apartments at market rates; and more supportive services are needed so that people living with a mental illness can live in their communities.

It is critical that a significant increase in community-based supportive services for people living with mental illness be part of any housing initiative targeted at people living with mental illness. Otherwise, such a program cannot achieve its objectives. Therefore, all such services must be eligible for funding under the Basket of Community Services portion of the Mental Health Transition Fund.

The federal government has begun to reinvest in affordable housing, primarily through the Canada Mortgage and Housing Corporation. It recently extended the National Homeless Initiative, which funds community supports such as emergency shelters and drop-in centres. It also established the Residential Rehabilitation Assistance Program, which provides assistance to low-income households, persons with disabilities and Aboriginal people to bring their homes up to

The Committee considers inexcusable the lack of affordable and appropriate housing for people living with mental illness.

norms. The norms have been adjusted over time to reflect the housing expectations of Canadians. Affordability, one of the elements used to determine core housing need, is recognized as a maximum of 30 per cent of the household income spent on shelter.” See: Canada Housing and Mortgage Corporation. (undated) Affordable housing. http://www.cmhc-schl.gc.ca/en/corp/faq/faq_002.cfm.

⁴⁰³ Canada Mortgage and Housing Corporation. (7 October 2005) Letter to the Standing Senate Committee on Social Affairs, Science and Technology.

⁴⁰⁴ Canadian Mental Health Association. (April 2005) Meeting the mental health needs of the people of Canada: A Submission to the Senate Standing Committee on Social Affairs, Science and Technology.

minimum health and safety standards, as well as repair shelters for victims of family violence and support home adaptations for low-income seniors.⁴⁰⁵

In addition, through the Affordable Housing Initiative, the federal government has agreements with the provinces and territories to share the cost of the construction of new affordable housing units, as well as to provide rental supplements to low-income households. The federal government does not have any housing programs, however, designed to meet the specific needs of people living with mental illness.

The Committee considers inexcusable the lack of affordable and appropriate housing for people living with mental illness. It is appalling that the proportion of people with mental illness in need of housing (27%) is nearly double that of the population as a whole (15%). According to the Canada Mortgage and Housing Corporation, approximately 56,500 people living with mental illness would need access to some form of affordable housing in order to bring down the proportion of people living with mental illness in need of housing to the national average.⁴⁰⁶

Approximately 56,500 people living with mental illness would need access to some form of affordable housing in order to bring down the proportion of people living with mental illness in need of housing to the national average. The Committee has recommended that 57,000 new affordable housing units be developed.

Ideally, the Committee would like to see all Canadians have access to affordable housing; but this is not a realistic goal in the short term. The Committee does want, however, an end to the current discrimination against people living with mental illness; this is why it has recommended the establishment of the Mental Health Housing Initiative as part of the Mental Health Transition Fund. This is also why the Committee has recommended that 57,000⁴⁰⁷ new affordable housing units be developed.

When the Mental Health Housing Initiative is launched, its initial focus should be on rent-subsidized units because of the need to act quickly to address the housing shortage.

The needs of people living with mental illness are not all the same — some require supportive services while others who are more independent have trouble finding adequate housing. The Committee believes that a program to meet the core housing need of people living with mental illness should establish a 60/40 mix of rent subsidies relative to the construction of new housing units.

The federal government pay the full share of the rent subsidies for the first three years.

The Committee also believes that when the Mental Health Housing Initiative is launched, its initial focus should be on rent-subsidized units because of the need to act quickly to address

⁴⁰⁵ Canada Mortgage and Housing Corporation. (22 November 2005) News release: National renovation and homeless programs extended.

⁴⁰⁶ Canada Mortgage and Housing Corporation. (7 October 2005) Letter to the Standing Senate Committee on Social Affairs, Science and Technology.

⁴⁰⁷ This figure represents a rounding-up of the estimate of 56,500 that was provided by the Canada Mortgage and Housing Corporation.

the housing shortage.⁴⁰⁸ The MHHI should be modelled on existing housing programs and “cost-shared” with the provinces in the same way that current supportive housing projects are — such as those targeted at people who are currently homeless.

The Committee feels so strongly that the housing shortage must be addressed immediately, that it is recommending that the federal government pay the full share of the rent subsidies for the first three years. This will kick-start the program and allow time for agreements to be reached subsequently with the provinces and territories.

More specifically, the Committee is recommending that in years 1 through 3 of the MHHI, 80% of the people provided with housing should receive a rent supplement of \$6,020 in the first year and \$4,250 annually thereafter. The remaining 20% should move into newly constructed units costing \$75,000 per unit.⁴⁰⁹ In years 4 through 7, the proportion of rent supplements to newly constructed units should be 60/40, and in years 8 through 10 the proportion should be 40/60.

The table below shows that the total cost would be \$2.24 billion over ten years at an average annual cost of \$224 million.

The MHHI would draw on evidence-based housing policies and best practices in supported housing. Consideration should also be given to innovative approaches by governments, health authorities and non-profit organizations, such as aggregating their subsidies to allow partnerships with tenants in the purchase of housing properties. Such approaches may help to address the economic realities of escalating rents and capital costs.

⁴⁰⁸ The federal government currently has cost-sharing agreements with the provinces and territories for rent supplements and the construction of new affordable housing units. See: Canada Mortgage and Housing Corporation. (7 October 2005) Letter to the Standing Senate Committee on Social Affairs, Science and Technology.

⁴⁰⁹ The cost of newly constructed units is based on the federal government contributing half of the costs to a maximum of \$75,000. It is likely that the actual cost of new units will be significantly lower.

Table: Costing Analysis of the Mental Health Housing Initiative

Year	# of new units	Cost of new units	# of new rent supplements	Cost of new rent supplements	# of continued rent supplements	Cost of continued rent supplements	Total rent supplement cost	Total annual cost	# of people removed from core housing need
1	1,129	84.675	4,520	27.210	0	0.000	27.210	111.885	5,649
2	1,129	84.675	4,520	27.210	4,250	19.210	46.420	131.095	11,295
3	1,129	84.675	4,520	27.210	9,040	38.420	65.630	150.305	16,947
4	2,260	169.500	3,388	10.198	13,560	28.815	39.013	208.513	22,595
5	2,260	169.500	3,388	10.198	16,948	36.015	46.212	215.712	28,243
6	2,260	169.500	3,388	10.198	20,336	43.214	53.412	222.912	33,891
7	2,260	169.500	3,388	10.198	23,724	50.414	60.611	230.111	39,539
8	3,388	254.100	2,258	6.800	27,112	57.613	64.413	318.513	45,186
9	3,388	254.100	2,259	6.797	29,371	62.413	69.210	323.310	50,832
10	3,388	254.100	2,258	6.797	31,629	67.212	74.008	328.108	56,478
Total	22,591	1694.325	33,887	142.815		403.325	546.140	2,240.465	

Source: Based on data provided by the Canada Mortgage and Housing Corporation. All costs are in millions of dollars.

The Committee therefore recommends:

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| 112 | <p>That the Government of Canada invest \$2.24 billion over ten years in the Mental Health Housing Initiative (MHHI) that is to be established as part of the Mental Health Transition Fund.</p> <p>That the MHHI have as its goal to reduce the percentage of Canadians living with mental illness in need of housing that is adequate, suitable and affordable from 27% to the national average (15%) of people in need of such housing, specifically by providing 57,000 people living with mental illness with access to affordable housing.</p> |
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That, over the life of the MHHI, 60% of its funds be allocated to providing rent supplements to people living with mental illness who would otherwise be unable to afford to rent accommodation at market rates, and the remaining 40% be devoted to the development of new affordable housing units.

That, in order to provide immediate assistance to as many people as possible, during the first three years of the MHHI, fully 80% of available funds be allocated to rent supplements; and that during this period the federal government pay the full share of the rent subsidies, after which the cost of the rent subsidies be shared according to existing federal-provincial-territorial arrangements.

That innovative approaches by governments, health authorities and non-profit organizations be supported, such as aggregation of subsidies to allow partnerships with tenants in the purchase of housing properties.

That, following the ten-year life of the MHHI, the Canada Mortgage and Housing Corporation be mandated to maintain the percentage of people living with mental illness who are in need of housing that is adequate, suitable and affordable at the same percentage as that of the population as a whole.

16.5.4 Other Elements in the Transition Fund

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

16.5.4.1 Initiatives with a Specific Focus on Substance Use Disorders, Addictive Behaviour and Concurrent Disorders

The Canadian Addiction Survey, a recent national epidemiological study of substance use and addictive behaviour across Canada, estimated that approximately 3.5 million Canadians had a substantial problem with alcohol consumption, 2.1 million with cannabis use, and 330,000 with other illicit drug use.⁴¹⁰ For many, such substance use problems and addictive behaviours have devastating consequences that result in profound harm and suffering. Morbidity and mortality data reveal high rates of suicide associated with alcohol and drug use, accidental deaths and disability (including motor vehicle

Mental illness and substance use disorders are often concurrent.

30% of people diagnosed with a mental illness will also have a substance use disorder in their lifetime, and 37% of people with an alcohol use disorder (53% who have a drug use disorder other than alcohol) also live with a mental illness.

⁴¹⁰ Canadian Centre on Substance Abuse. (November 2005) Brief to the Standing Senate Committee on Social Affairs, Science and Technology.

related deaths and disability), violent behaviour and criminal activity, physical illness and the spread of infectious diseases such as hepatitis C, tuberculosis and HIV/AIDS. A 1996 study by the Canadian Centre on Substance Abuse, *The Costs of Substance Abuse in Canada*, estimated that the economic cost of substance use problems in 1992 in Canada was \$18.4 billion, including the direct costs of health care and law enforcement and indirect costs due to loss of productivity.⁴¹¹

Publicly funded prevention, treatment and support services for substance use problems and addiction are provided primarily by provincial and territorial governments as a category of general health services. Ideally, a broad set of coordinated services and supports would be available to address substance use problems, such as the continuum of services described in the recent B.C. government framework, *Every Door is the Right Door: A British Columbia Framework to Address Problematic Substance Use and Addiction*.⁴¹²

- *Health Promotion and Primary Prevention Initiatives*, including universal and selective prevention activities;
- *Secondary Prevention/Early Intervention*, including indicated prevention, early identification and early treatment activities;
- *Standard Treatment and Self-management with Selected Supports*;
- *Intensive Treatment, Long-term Rehabilitation and Support*.

Programs that are designed to meet the needs of specific populations, such as older adults, youth, and Aboriginal peoples, are also required for optimal prevention and treatment of substance use disorders. In addition, initiatives are required to address other addictive behaviours such as problem gambling.

Throughout most of Canada, a complete and comprehensive set of services and supports to address substance use problems and addictive behaviours is unavailable. It is impossible to obtain an accurate estimate of the total funding allocated by the provinces and territories to address substance use and other addictive behaviours, because expenditures for these

It has been common for clients to be excluded from mental health services if they admitted to substance use problems. Similarly, clients were often excluded from addiction treatment programs if they admitted to the use of antidepressant medications.

services are blended into overall health care costs. National figures on the number of Canadians involved in addiction treatment programs are also not available. The Canadian Centre for Substance Abuse estimates that approximately \$400 million per year is currently being spent across the country on substance use disorder treatment services.⁴¹³ A recent national epidemiological survey undertaken by Statistics Canada found that only a small

⁴¹¹ Canadian Centre on Substance Abuse. (1996) *The Costs of Substance Abuse in Canada*.

⁴¹² British Columbia Ministry of Health. (2004) *Every Door is the Right Door: A British Columbia Framework to Address Problematic Substance Use and Addiction*.

⁴¹³ Canadian Centre on Substance Abuse. (2005) *Addiction Treatment Indicators in Canada*.

proportion of individuals with substance use disorders and addictive behaviours receive treatment.⁴¹⁴

The relationship between services for mental illness (such as treatment for depression, anxiety disorders and schizophrenic disorders) and services for substance use disorders (including treatment for problematic alcohol use, withdrawal management services, methadone maintenance for opiate addiction and needle exchange programs) has been the subject of much discussion and debate across Canada. In previous decades, services for the two types of disorder were administered separately; they developed divergent treatment philosophies, used different terminology and constituted different “cultures” that were often in conflict.

Mental illness and substance use disorders are often concurrent; it is quite common for people to suffer from both. Research has shown that 30% of people diagnosed with a mental illness will also have a substance use disorder in their lifetime, and 37% of people with an alcohol use disorder (53% who have a drug use disorder other than alcohol) also live with a mental illness.⁴¹⁵

The “culture clash” between mental health services and addiction services has created substantial problems for clients, particularly those with concurrent disorders. As a result of conflicting approaches to treatment, clients have often received confusing and inconsistent information and advice. It has been common for clients to be excluded from mental health services if they admitted to substance use problems. Similarly, clients were often excluded from addiction treatment programs if they admitted to the use of antidepressant medications.

Efforts to improve the integration of mental health and addiction services are currently underway in many parts of Canada. Most clients welcome greater integration but some providers do not welcome the change. Providers of treatment for addiction often express concerns about what they anticipate to be the “medicalization” of services; mental health providers fear, on the other hand, that their clients’ symptoms will be inadequately addressed and treated. In many jurisdictions, providers from both groups are receiving joint training to develop more comfort when providing treatment to people with mental health problems, substance use disorders or concurrent disorders. The administration of mental health and addiction services has been integrated in some provinces and territories, whereas in others separate administrative structures have been maintained.

The federal government should provide an additional \$50 million to focus service reform initiatives that address substance use problems, addictive behaviour and concurrent disorders, essentially doubling the amount spent on Canada’s Drug Strategy.

⁴¹⁴ Statistics Canada. (2004) Canadian Community Health Survey 1.2.

⁴¹⁵ Skinner, W., O’Grady, C., Bartha, C., and Parker, C. (2004) Concurrent substance use and mental health disorders: An information guide. Toronto: Centre for Addiction and Mental Health.

Canada's Drug Strategy⁴¹⁶ was developed as a federally coordinated initiative to reduce the harm associated with the use of narcotics, controlled substances, alcohol, and prescription drugs. It includes education, prevention and health promotion initiatives as well as enhanced enforcement measures. The Strategy involves a number of federal departments together with provincial and territorial governments, addictions agencies and non-governmental organizations, such as the Canadian Centre on Substance Abuse. The federal government has committed \$245 million over five years, or an average of \$49 million per year, to this strategy.⁴¹⁷

The Committee is convinced that the federal government can and should do more to address substance use problems, addictive behaviour, and concurrent disorders. Specifically, the Committee believes that the federal government should provide an additional \$50 million for services and supports for people living with concurrent disorders. The Committee therefore recommends:

113 That the Government of Canada include as part of the Transition Fund \$50 million per year to be provided to the provinces and territories for outreach, treatment, prevention programs and services to people living with concurrent disorders. As with the rest of the Transition Fund, this money would be managed by the Canadian Mental Health Commission, but in respect of this component of the fund there should be close consultation with the Canadian Centre for Substance Abuse, as well as the provinces, territories, and other stakeholders.

In concert with the Drug Strategy funds, this additional federal investment represents a significant opportunity to improve prevention and treatment services for people with concurrent disorders. It should be noted that in 2004-05, the federal government collected almost \$1.3 billion in excise duties on alcohol; its expenditures on substance use are less than 4% of what it collects in excise duties.⁴¹⁸

16.5.4.2 Telemental Health⁴¹⁹

As discussed in Chapter 12, there is enormous potential to telemental health, especially because the process of psychiatric diagnosis is not primarily a physical one, but relies on verbal and non-verbal communication. One of the most frequently cited

It is important for the federal government to assist with the deployment of telemental health initiatives throughout the country.

⁴¹⁶ For more information, see: Health Canada. (October 2005) Canada's drug strategy. http://www.hc-sc.gc.ca/ahc-asc/activit/strateg/drugs-drogues/index_e.html.

⁴¹⁷ Health Canada. (May 2003) Canada's drug strategy. http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2003/2003_34bk1_e.html.

⁴¹⁸ Receiver General of Canada, *Public Accounts of Canada, 2004-05*, section 4.7. This amount does not include GST collected on the sale of alcoholic beverages.

⁴¹⁹ See Chapter 12, "Telemental Health in Canada," for a more detailed discussion of telemental health.

benefits of telehealth is its potential to increase access to health services generally in rural and remote communities, and in particular to mental health services. This is especially important for northern Aboriginal communities with no or limited access to psychiatric services.

Funding for telemental health services comes largely from provincial and territorial governments. All provinces and territories have been experimenting with telemental health and some have already embarked on program implementation, despite the high upfront costs. The Committee believes that it important for the federal government to assist with the deployment of telemental health initiatives throughout the country.

Over time, and once the infrastructure is in place, the provinces and territories should find that the savings (e.g., reduced transportation and other costs) made possible through the implementation of telemental health services are sufficient to fund the operation of those services. The Committee recommended in Chapter 12 that the federal government assist provinces with the transition towards this “steady state” and recommends:

114	That the Government of Canada provide the provinces and territories with \$2.5 million per year to help them move forward with their plans for telemental health. This money would be part of the Mental Health Transition Fund and be administered by the Canadian Mental Health Commission.
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16.5.4.3 Peer Support

In Chapter 10, the Committee documented the tremendous importance of self-help and peer support for people living with mental illness and their families. The Committee recognizes the financial difficulties faced by many of the organizations that provide these services across the country. Hence, the Committee recommended in Chapter 10 that a designated national fund be established to provide stable funding to existing peer development initiatives, build new initiatives and establish a network of self-help and peer support initiatives. Therefore, the Committee recommends:

A designated national fund be established to provide stable funding to existing peer development initiatives, build new initiatives and establish a network of self-help and peer support initiatives.

115	That the Government of Canada provide the provinces and territories with \$2.5 million per year for peer support and self-help initiatives. This money would be part of the Mental Health Transition Fund and be administered by the Canadian Mental Health Commission.
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16.6 RESEARCH

In addition to the various elements of the Transition Fund, the Committee reiterates its support for research. Research into mental illness and addiction is of enormous importance. It can lead to meaningful improvements in the lives of people living with mental illness and addiction in Canada. That is why, in Chapter 11, the Committee recommended:

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| 116 | <p>That the federal government commit \$25 million per year for research into the clinical, health services and population health aspects of mental health, mental illness and addiction.</p> <p>That these funds be administered by the Canadian Institutes of Health Research (CIHR), through the Institute of Neurosciences, Mental Health and Addiction under the guidance of a multi-stakeholder board and in consultation with the Canadian Mental Health Commission.</p> <p>That this \$25 million be incremental to the funding currently provided to the CIHR.</p> |
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16.7 FUNDING THE FEDERAL INVESTMENT IN MENTAL HEALTH

The Committee has always believed that the responsible course of action is not simply to recommend that the federal government spend more money in a particular area but also to suggest how it can be raised to pay for implementation of the Committee's recommendations. The Committee took this approach in its October 2002 final report on the acute care (hospital and doctor) system. In that report, the Committee recommended that \$5 billion be raised annually through a National Health Care Insurance Premium. While the federal government decided not to adopt the Committee's recommendation, nonetheless, in the September 2003 federal/provincial/territorial health accord, it did agree to contribute to the provinces and territories essentially the same amount of money for health care as had been recommended by the Committee.

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

This revenue would still go into the Consolidated Revenue Fund but be subject to the requirement that it be spent entirely and exclusively on the programs recommended.

Based on the calculations presented in this chapter, the amount of money that is required for mental health, mental illness and addiction supports and services is only one-tenth of the amount of new spending that the Committee recommended be put into the acute care system.

The Committee believes that the new revenue it is recommending be raised should be earmarked for spending on mental health, mental illness and addiction. This revenue would still go into the Consolidated Revenue Fund but be subject to the requirement that it be spent entirely and exclusively on the programs recommended in sections 16.3 and 16.4 above.

Objections have sometimes been raised to earmarked taxes because they reduce governments' ability to adjust their spending as priorities change. While the Committee is sympathetic to this objection in general, it believes that an exception ought to be made for the money recommended for mental health, mental illness and addiction for the following reasons:

- Given that Canadians living with a mental illness or a substance use problem have been neglected, or at best substantially under-served, for so long, an extraordinary signal of support is necessary from the federal government. Such a signal would be given by its preparedness to earmark a source of new revenue specifically for them.
- A clear precedent for earmarked taxes has been established by the federal government's recent decision to give a certain percentage of gas taxes directly to municipalities.
- Given that mental health and substance use issues touch the lives of essentially the entire population, the Committee believes that Canadians will agree with the proposal to pay a small amount to improve the lives of people living with these problems.

The Committee believes that the proposal outlined below will be acceptable to the Canadian public. In fact, there is considerable research evidence to suggest that taxes earmarked for a specific purpose are likely to be more acceptable to voters than are tax increases that provide governments with additional general revenue.

The Committee believes that the proposal outlined below will be acceptable to the Canadian public.

The Committee realizes that there is no "best" way of raising the required revenue. Four tests for examining possible sources of revenue were used:

1. The revenue should be easy to collect and entail minimal additional administrative costs — that is, the method of raising funds should be very efficient.
2. It should be easy to explain to Canadians the nature of, and the rationale for the chosen source of revenue.
3. The method proposed for raising the revenue should be politically feasible, that is, acceptable to most Canadians.

4. It should be easy for people outside government to calculate how much money was raised and to verify that it was indeed spent on mental illness and substance use problems; that is, it should be easy to hold government accountable.

After careful consideration, the Committee recommends:

117	That, in order to raise additional revenue to pay for the recommended federal investments in mental health, mental illness and addiction initiatives, the Government of Canada should raise the excise duty on alcoholic beverages by a nickel a drink, that is by 5 cents a standard drink.
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One standard drink in Canada is 13.6 g of alcohol — a 12-ounce bottle of beer, a five-ounce glass of wine or 1.5 ounces of 80-proof liquor.⁴²⁰ Five cents per drink translates into 5 cents on a bottle of beer, approximately 25 cents on a bottle of wine, and approximately 85 cents on a bottle of spirits.

For the reasons explained below, the Committee believes that this increase in excise duty should not apply to alcoholic beverages with an alcohol content of 4% and lower; it should not apply to light beer or other low-alcohol beer.

In fact, the Committee believes that society would benefit from a shift in consumption from higher- to lower-alcohol beer. Therefore, the Committee recommends:

118	That the Government of Canada lower the excise duty by 5 cents a drink on beer of alcohol content between 2.5% and 4%, and the excise duty on beer of alcohol content under 2.5% should be eliminated entirely.
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In all, these changes to the federal excise tax on alcohol would raise approximately \$478 million per year. The calculation is presented in the box at the following page.

The Committee believes that Canadians are not likely to object to an increase of only 5 cents per drink, especially since the federal excise duty on alcohol has not risen since 1986;⁴²¹ the Consumer Price Index (CPI) has risen by 64.25% since then.⁴²² In real terms (i.e., after inflation), the increase in the excise duty would be about half the rate of inflation. In 2004-

⁴²⁰ Health Canada. (2000) *Straight Facts about Drugs and Drug Abuse*, p. 30.

⁴²¹ The excise duties and taxes were changed for alcohol (beer, spirits and wine) were changed in 1991 with the introduction of the GST. This change in rates was “revenue-neutral”; that is, the excise tax and duty rates were increased to produce the same combined sales and excise tax and duty revenues as under the old federal sales tax system.

⁴²² This is according to an inflation calculator on the Bank of Canada’s website: http://www.bankofcanada.ca/en/rates/inflation_calc.html.

2005, the revenue from excise duties on alcohol was \$1,286,128,496.⁴²³ The revenues of \$478 million from the “nickel a drink proposal” would increase this amount by 37%.

REVENUE FROM THE “NICKEL A DRINK” PROPOSAL

Beer

According to Statistics Canada, approximately 2,232,756,000 litres of beer were sold in Canada in 2004.* The typical bottle of beer (one standard drink) contains 341 ml. Thus, the equivalent of 6,547,671,544 bottles of beer was sold in 2004. Based on information from the industry, approximately 82% of the beer sold in Canada has an alcohol content greater than 4%. If the excise duty on this beer were raised by 5 cents, this would generate \$268,454,534 in revenue annually, provided consumption remained at the same level.

If the excise duty on beer with an alcohol content of 4% and lower were reduced by 5 cents from the current rate, this would lower revenues by \$58,929,044.

Very little beer sold in Canada has an alcohol content of 2.5% and lower. If the excise duty on this beer were eliminated, this would reduce revenues by about \$740,000.

Spirits and wine

In 2004, the total volume of absolute alcohol from spirits sold in Canada was 54,683,000 litres; from wine, the total was 38,611,000 litres. One standard drink contains 13.6 g of alcohol, or 17.325 ml. If the excise duty were increased by 5 cents per standard drink, this would generate revenue of \$269,246,753 from spirits and wine, provided consumption remained at the same level.

The total revenue from the “Nickel a Drink” proposal would be approximately **\$478 million per year.**

* Information on the amount of beer, spirits and wine sold in Canada was obtained from Statistics Canada, *The Control and Sale of Alcoholic Beverages in Canada*, 2004, 63-202-XIE.

It should be noted that while the current excise duty on spirits is based on volume of alcohol, the excise duty on wine is based on volume sold. Consequently, unless the federal government decides to change the method of calculating the excise duty on wine (there would be some merit in doing this, as fortified wines are taxed less on a per standard drink basis than other wines), the revenue generated would likely differ slightly from the calculation given.

Other important benefits could be gained by shifting consumption away from higher-strength to lower-strength beer. There is good evidence from Australian studies that the consumption of lower strength beer leads to a measurable reduction in impaired driving, and

⁴²³ Receiver General of Canada. (2005) *Public Accounts of Canada*, 2005, section 4.7.

that geographic regions with higher proportional sales of lower-strength beer also have less alcohol-related violence and fewer hospital admissions related to alcohol consumption.⁴²⁴

In 2001, the Australian federal government, persuaded by the evidence that reducing taxes on lower-strength beers was good for public health and safety, introduced differential excise tax rates for beer as follows:

- Low-alcohol beer (not exceeding 3% alcohol/volume): \$15.96 per litre of alcohol;
- Mid-strength beer (>3%, <=3.5% alcohol/volume): \$17.33 per litre of alcohol;
- High-alcohol beer (exceeding 3.5% alcohol/volume): \$22.68 per litre of alcohol.

The combination of less alcohol per drink and lower tax rates per unit of alcohol resulted in substantial retail price advantages for lower-strength beer. As a result, about 40% of the volume of the Australian beer market now consists of low- to mid-strength beer, between 2.5% and 3.8% alcohol.⁴²⁵

The Australian experience suggests that there could be multiple benefits for Canada were it to introduce simultaneously:

- A 5-cent (nickel) excise duty increase on a standard drink of alcohol with the proceeds earmarked for mental health and substance use problems; and
- A marked reduction in taxes on lower-strength beer.

These benefits would include:

- More mental health and substance use services funded from the approximately \$478 million per year that would be raised by the increased excise duty;
- Incentives for the manufacture, marketing and sales of products with a lower alcohol content;
- A probable reduction in the harms associated with alcohol due to a shift of consumption to products of lower strength.

The Committee has anticipated a variety of possible objections to its recommendation for a “nickel a drink” increase in the alcohol excise tax. Our responses to them are as follows.

- To those who say that government should not increase any tax, we say that there is no free good or service. We say also that services must be improved now for Canadians living with a mental illness or a substance use problem;

⁴²⁴ Tim Stockwell. (October 2005) Brief to the Standing Senate Committee on Social Affairs, Science and Technology.

⁴²⁵ *Ibid.*

- To those who may say it is wrong to raise money based on alcohol consumption to help provide services to people living with a mental illness, we think this a misunderstanding of our proposal. Because we are recommending increased federal expenditures of nearly \$500 million per year out of the Consolidated Revenue Fund, we need to recommend a way to replenish that fund with an equivalent amount. We insisted that our revenue-raising proposal meet the four tests we set out earlier in this section. The Committee believes that our proposal satisfies all four tests.
- Our revenue-raising proposal is not linked to our expenditure proposal in any causal way. The only connection is that the amounts of money are equivalent. Indeed, the Committee has deliberately avoided raising questions here about the nature of a causal link, if any, between mental health and substance use disorders. Rather, the Committee has simply made a recommendation to the government that is *both* economically sound and, in our view, politically feasible.

16.8 TOTAL COSTS AND OPTIONS FOR BALANCING REVENUES AND EXPENDITURES

The total annual cost of implementing the Committee’s recommendations is outlined in the following table.

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

The \$17 million budgeted for the Mental Health Commission is broken down as follows:

- Anti-stigma program: \$5 million per year. This investment would be supplemented by the Commission’s solicitation of public service announcements using the same communications materials developed for the paid social marketing campaign. In all, as much as \$8 million a year, a significant communications undertaking, would fund the anti-stigma campaign.
- Knowledge Exchange Centre: \$60 million over ten years, an average of \$6 million per year. The Committee has prepared and will submit to the federal

government a detailed ten-year budget for the Knowledge Exchange Centre. Costs will be higher in the initial years as the information infrastructure required for the Centre is constructed, and will decline gradually as a stable operating environment is established.

- Operation of the Commission: \$6 million per year. This includes the basic operating costs of the Commission, its Board, and the advisory committees and working groups it will create, as well as the Commission's contribution to joint projects undertaken with other governments and non-governmental organizations. The Committee has prepared a detailed budget, based on the operation of the Health Council of Canada, for submission to the Government of Canada.

Given that the anticipated revenue generated from the “nickel a drink” proposal would be \$478 million per year, a shortfall of \$58 million per year is left between the Committee's recommendations and its proposed source of revenue. The Committee believes that the cost estimates for the construction of new housing units may be high,⁴²⁶ so the discrepancy between revenues and expenditures may disappear once the programs are in place.

Should a shortfall persist, the Committee's preference would be that it be made up from general revenues. Failing that, there are several other ways to bridge the potential gap:

- The housing costs could be spread out over 15 rather than 10 years. This would reduce the average annual cost by \$62 million, from \$224 million to \$162 million.
- The Canada Mortgage and Housing Corporation has a large annual surplus from its mortgage insurance program. By 2009, it is estimated that CMHC will have \$4.5 billion more than is necessary in capital reserves for that program. Some of these funds could be spent on the housing needs of people living with mental illness.
- The least palatable option from the Committee's perspective would be to leave in place the excise duty on beer with an alcohol content of 4% and under. Were this tax to remain, revenue would increase by approximately \$58 million.

16.9 CONCLUSION

As noted earlier, the Committee believes that implementing the recommendations contained in this chapter — together with all those made throughout this report — will allow, for the first time, national resources to be channelled into fostering the mental health of Canadians. They will also establish a solid basis for maintaining a national focus on mental health issues and pave the way for the further development of a national approach to mental health, mental illness and addiction in Canada.

⁴²⁶ In particular, the calculation may be high as it was made based on the federal government's 50% contribution being \$75,000 per new housing unit.

EPILOGUE — THE HUMAN FACE OF A TRANSFORMED SYSTEM

In the epilogue we return to where we started: to looking at the impact of the mental health system on people living with a mental illness. We do so in the hope that readers of this report will always keep in mind that the mental health system is not about governments or programs or politics or service providers. It is about helping people with illness live the best life they possibly can.

EMMY'S STORY

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

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

THE WAY IT IS

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

Age Six

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

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

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

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

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

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

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

Age Fifteen

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

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

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

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

Age Twenty-Three

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

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

Age Thirty-Four

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

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

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

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

Age Thirty-Eight

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

Age Sixty-Six

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

THE WAY IT SHOULD BE

Age Six

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

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

Age Fifteen

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

Age Twenty-Three

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

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

Age Thirty-Four

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

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

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

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

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

Age Thirty-Eight

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

Age Sixty-Six

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

CHAPTER 4: LEGAL ISSUES

Recommendation 1 (page 67):

That the provinces and territories establish a uniform age at which youth are deemed capable of consenting to the collection, use and disclosure of their personal health information.

Recommendation 2 (page 69):

That health care professionals take an active role in promoting communication between persons living with mental illness and their families. This includes asking persons living with mental illness if they wish to share personal health information with their families, providing them with copies of the necessary consent forms, and assisting them in filling them out.

Recommendation 3 (page 69):

That health care professionals have discretion to release personal health information, without consent, in circumstances of clear, serious and imminent danger for the purposes of warning third parties and protecting the safety of the patient.

That this discretion be governed by a clearly defined legal standard set out in legislation, and subject to review by privacy commissioners and the courts.

Recommendation 4 (page 70-71):

That all provinces and territories empower mentally capable persons, through legislation, to appoint substitute decision makers and to give advance directives regarding access to their personal health information.

That provisions in any provincial legislation that have the effect of barring persons from giving advance directives regarding mental health treatment decisions be repealed.

That all provinces and territories make available forms and information kits explaining how to appoint substitute decision makers and make advance directives.

That all provinces and territories make available community-based legal services to assist individuals in appointing substitute decision makers and making advance directives.

That all provinces and territories undertake public education campaigns to educate persons with mental illness, and their families, about the right to appoint a substitute decision maker and make an advance directive.

Recommendation 5 (pages 71-72):

That where a person is diagnosed with a mental illness that results in his/her being found mentally incapable, and where there is no previous history of mental illness or finding of mental incapacity, and where there is no named substitute decision maker or advance directive, the law create a presumption in favour of disclosure of personal health information to the affected person's family caregiver(s).

That the provinces and territories enact uniform legislation setting out this presumption.

That the legislation specify an "order of precedence" for relatives (i.e., if the person is married, or living in a common-law relationship, disclosure would be to his or her spouse or common-law partner, and if there is no spouse or common-law partner, to the person's children, etc.).

That the legislation specify the information to be disclosed, including: diagnosis, prognosis, care plan (including treatment options, treatment prescribed, and management of side-effects), level of compliance with the treatment regime, and safety issues (e.g., risk of suicide).

That the legislation specifically bar the release of counselling records.

That the legislation oblige the person disclosing the personal health information to notify the mentally incapable person, in writing, of the information disclosed, and to whom it was disclosed.

Recommendation 6 (page 82):

That the *Criminal Code* be amended to grant Review Boards the same powers to order mental health assessments as those it currently confers on courts.

Recommendation 7 (page 85):

That the *Criminal Code* be amended to grant Review Boards the same powers to order treatment as those it currently confers on courts.

Recommendation 8 (page 87):

That the Government of Canada, in consultation with provincial and territorial ministers responsible for justice, develop proposed amendments to the *Criminal Code* to address the issue of convicted persons who become unfit to be sentenced after a verdict has been reached.

That these amendments be brought before Parliament within one year of the tabling of this report in the Senate.

CHAPTER 5: TOWARDS A TRANSFORMED DELIVERY SYSTEM

Recommendation 9 (pages 117-118):

That the Government of Canada create a Mental Health Transition Fund to accelerate the transition to a system in which the delivery of mental health services and supports is based predominantly in the community.

That this Fund be made available to the provinces and territories on a per capita basis, and that the Fund be administered by the Canadian Mental Health Commission that has been agreed to by all Ministers of Health (with the exception of Quebec).

That the provinces and territories be eligible to receive funding from the Mental Health Transition Fund for projects that:

- Would not otherwise have been funded; that is, projects that represent an increase in provincial or territorial spending on mental health services over and above existing spending on services and supports plus an increment equal to the percentage annual increase in overall spending on health; and that
- Contribute to the transition toward a system in which the delivery of mental health services and supports is based predominantly in the community.

That in allocating the resources from the Mental Health Transition Fund priority should be given to people living with serious and persistent mental illness and that a strong focus should be maintained on meeting the mental health needs of children and youth.

Recommendation 10 (page 122):

That services and supports directed at enabling people living with mental illness to be housed in community settings be eligible for funding as part of the Basket of Community Services component of the Mental Health Transition Fund and administered by the Mental Health Commission.

Recommendation 11 (page 123):

That, as part of the Mental Health Transition Fund, the Government of Canada create a Mental Health Housing Initiative that will provide funds both for the development of new affordable housing units and for rent supplement programs that subsidize people living with mental illness who would otherwise not be able to rent vacant apartments at current market rates.

- That in managing the housing portion of the Mental Health Transition Fund, the Canadian Mental Health Commission should work closely with the Canada Mortgage and Housing Corporation.

Recommendation 12 (page 124):

That a Basket of Community Services that have demonstrated their value in enabling people living with mental illness, in particular those living with serious and persistent illnesses, to live meaningful and productive lives in the community be eligible for funding through the Mental Health Transition Fund.

That this Basket of Community Services include, but not be limited to, such things as Assertive Community Treatment Teams (ACT), Crisis Intervention Units and Intensive Case Management programs, and that the only condition for establishing the eligibility of a particular service for funding through the Mental Health Transition Fund be that it be based in the community.

Recommendation 13 (page 127):

That collaborative care initiatives be eligible for funding through the Mental Health Transition Fund.

That the Knowledge Exchange Centre to be established as part of the Canadian Mental Health Commission (see Chapter 16) actively pursue the promotion of best practices in the development and implementation of collaborative care initiatives.

Recommendation 14 (page 132):

That compassionate care benefits be payable up to a maximum of 6 weeks within a two year period to a person who has to be absent from work to provide care or support to a family member living with mental illness who is considered to be at risk of hospitalization, placement in a long term care facility, imprisonment, or homelessness, within 6 months.

That eligibility for compassionate care benefits be determined on the advice of mental health professionals and that recipients of compassionate care benefits be exempt from the two-week waiting period before EI benefits begin.

Recommendation 15 (page 133):

That initiatives designed to make respite care services more widely available to family caregivers and better adapted to the needs of individual clients as they change over time, be eligible for funding through the Mental Health Transition Fund.

CHAPTER 6: CHILDREN AND YOUTH

Recommendation 16 (page 137):

That school boards mandate the establishment of school-based teams made up of social workers, child/youth workers and teachers to help family caregivers navigate and access the mental health services their children and youth require, and that these teams make use of a variety of treatment techniques and work across disciplines.

Recommendation 17 (page 140):

That mental health services for children and youth be provided in the school setting by the school-based mental health teams recommended in section 6.2.1 above.

That teachers be trained so that they can be involved in the early identification of mental illness.

That teachers be given the time and the practical resources and supports necessary to take on this new role.

Recommendation 18 (page 144):

That students be educated in school about mental illness and its prevention, and that the Canadian Mental Health Commission (see Chapter 16) work closely with educators to develop appropriate promotion campaigns in order to reduce stigma and discrimination.

Recommendation 19 (page 146):

That provincial and territorial governments work to eliminate any legislative, regulatory or program “silos” that inhibit their ability to deal in an appropriate fashion with the transition from adolescence to adulthood, and that they adopt the following measures:

- Determine age cut-offs for mental health services for children and youth by clinical, rather than budgetary or other bureaucratic, considerations.
- Where age cut-offs are employed, link services for children and youth to adult services to ensure a seamless transition.
- Where age cut-offs are employed, avoid any “gaps” of time where individuals are ineligible for treatment under both the children and youth and the adult systems.

Recommendation 20 (page 148):

That provincial and territorial governments coordinate mental health and social services, and pay particular attention in this regard to ensuring that age cut-offs for social services for children and youth be synchronized with those established for mental health services.

Recommendation 21 (page 149):

That governments take immediate steps to address the shortage of mental health professionals who specialize in treating children and youth.

Recommendation 22 (page 150):

That the use of tele-psychiatry be increased in rural and remote areas, to facilitate the sharing of mental health personnel who specialize in treating children and youth with these communities.

That tele-psychiatry be employed both for consultations and for the purposes of education and training of health professionals who work in rural and remote areas.

Recommendation 23 (page 151):

That standardized, evidence-based group therapies be used, where clinically appropriate, to reduce wait times for children and youth who need access to mental health services.

Recommendation 24 (page 152):

That provincial and territorial governments encourage their health, education and justice institutions to work closely together in order to provide seamless access to mental health services for children and youth.

That greater use be made of case conferencing so as to coordinate and prioritize mental health service delivery to children and youth.

Recommendation 25 (page 153):

That evidence-based family therapies be employed so that all family members are provided the assistance they need.

That professionals interacting with children and youth with mental illness be offered training opportunities to ensure that they can properly address the mental health needs of their younger clients.

That family-based treatment of mental illness be integrated into the curriculum of mental health professionals and primary care physicians.

That professionals interacting with family caregivers be compensated for this time, in addition to the time spent with the young person living with mental illness.

That all practitioners working with children and youth be trained in children's rights.

CHAPTER 7: SENIORS

Recommendation 26 (page 159):

That the Knowledge Exchange Centre to be created as part of the Canadian Mental Health Commission (see Chapter 16) have as one of its goals to foster the sharing of information amongst gerontology researchers themselves, and also between providers of specialist care to seniors and other mental health and addiction care providers.

That the Canadian Mental Health Commission encourage research on the broad ranges of ages, environments (i.e., community versus institutional), co-morbidities and cultural issues that have an impact on seniors' mental health, and that it promote best practices in senior-specific mental health programs in order to counter the marginalization of older adults within treatment programs that claim to be suited to all ages.

Recommendation 27 (page 163):

That money from the Mental Health Transition Fund (see Chapter 16) be made available to the provinces and territories for initiatives designed to facilitate seniors with a mental illness living in the community; these initiatives could include, amongst other things, the provision of:

- home visits by appropriately compensated mental health service providers;
- a range of practical and social support services delivered in their homes to seniors living with mental illness;
- a level of support to seniors living with mental illness that is, at a minimum, equivalent to the level of support available to seniors with physical ailments, regardless of where they reside;
- a more widely available supply of affordable and supportive housing units for seniors living with mental illness.

Recommendation 28 (page 164):

That seniors with a mental illness who are living with family caregivers be eligible for all of the health and support services that would be available to them if they lived alone in their own home.

Recommendation 29 (page 166):

That efforts be made to shift seniors with a mental illness from acute care to long-term care facilities, or other appropriate housing, where it is clinically appropriate to do so, by making alternatives to hospitalization more widely available.

That staffing competencies in long term care facilities be reviewed and adjusted, through the introduction of appropriate training programs, to ensure that the devolution of responsibility for patients living with a mental illness from acute care facilities to long-term care facilities is done in a way that ensures that clinically appropriate mental health services are available to residents on-site.

Recommendation 30 (page 168):

That a range of institutionally based services for seniors living with a mental illness be integrated (e.g., supportive housing units and long-term care facilities) by locating them adjacent to each other, to make the transition(s) between different institutional settings efficient and safe.

That every effort be made to facilitate aged couples being able to continue to live together, or in close proximity to one another, regardless of the level of services and supports that they each may require.

CHAPTER 8: WORKPLACE AND EMPLOYMENT

Recommendation 31 (page 182):

That the Canadian Mental Health Commission (see chapter 16) work with employers to develop and publicize best management practices to encourage mental health in the workplace.

Recommendation 32 (page 184):

That the Knowledge Exchange Centre to be created as part of the Canadian Mental Health Commission (see Chapter 16) assist employers, occupational health professionals and mental health care providers in developing a common language for fostering the management of mental illness in the workplace and in sharing best practices in this area.

Recommendation 33 (page 188):

That employers increase the number of counselling sessions offered through Employee Assistance Programs (EAPs), especially in communities where access to other mental health services is limited.

That research be undertaken to evaluate EAPs, and that the results be shared through the Knowledge Exchange Centre that the Committee recommends be created as part of the Canadian Mental Health Commission (see Chapter 16) with a view to strengthening the effectiveness of these programs.

Recommendation 34 (page 192):

That the Department of Human Resources and Social Development, through the Opportunities Fund for Persons With Disabilities, facilitate the establishment of a nation-wide supported employment program to assist persons living with a mental illness to obtain and retain employment.

That this program promote the development of, and provide support for, alternative businesses that are both owned and operated by persons living with mental illness.

That the Department of Human Resources and Social Development report on how many people living with mental illness are assisted through the Opportunities Fund for Persons With Disabilities.

Recommendation 35 (page 193):

That the Canadian Mental Health Commission (see Chapter 16) work closely with provincial and territorial governments as well as with Workers' Compensation Boards, employers and trade unions across the country to develop best practices with respect to compensation for occupational stress related claims.

Recommendation 36 (page 198):

That benefit levels and earning exemptions amounts for social assistance programs for persons living with a mental illness be increased to reduce financial hardship and increase the incentive to work.

That recipients of supplementary aid, such as help with the costs of medication, continue to be eligible for assistance for an extended period of time even if their incomes increase to levels where they are no longer eligible for financial aid for shelter or other living expenses.

Recommendation 37 (page 202):

That the eligibility criteria for Canada Pension Plan — Disability (CPP-D) benefits be modified so that persons living with a mental illness are no longer required to demonstrate that their illnesses are severe and prolonged, but only that their illness has been diagnosed and that they are unemployable and need income support.

That the Government of Canada review how to coordinate better Employment Insurance (EI) sickness benefits and CPP-D, and examine how to eliminate structural barriers (i.e., financial disincentives) that limit opportunities to return to work.

That the Government of Canada grant authority to the CPP to permit it to sponsor research on, and the testing of, new approaches that could target people with episodic disabilities, particularly episodic mental illness.

That the Government of Canada explore ways to provide incentives to employers who hire persons living with mental illness, including the possibility of offering them CPP premium “holidays”.

Recommendation 38 (page 203):

That Employment Insurance (EI) sickness benefits be modified so that persons living with a mental illness can qualify more easily. Specifically, for persons living with a mental illness, the number of hours to be worked since the last claim should be reduced.

Recommendation 39 (page 204):

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

CHAPTER 9: ADDICTION

Recommendation 40 (page 208):

That a portion of the funding for peer support in the Mental Health Transition Fund (see Chapter 16) be made available to develop and sustain self-help and peer support groups for people and their families living with addiction (including problem gambling).

Recommendation 41 (page 210):

That treatment resources targeted at addictions include addiction to legal substances such as alcohol, tobacco, and prescription medications, and to behaviors such as gambling.

Recommendation 42 (page 211):

That provincial and territorial governments commit a fixed portion of funds derived from gambling to evidence-based prevention, awareness and treatment programs for gambling addiction, and to gambling addiction research.

That Statistics Canada ensure that in addition to alcohol and drug use, the prevalence of problem gambling among the general population is measured and reported upon through regular survey work.

Recommendation 43 (page 213):

That the Government of Canada conduct an assessment of the outcomes of existing programs dedicated to addiction problems for First Nations, Inuit and Métis peoples.

That the results of this assessment be shared through the Knowledge Exchange Centre to be created as part of the Canadian Mental Health Commission (see Chapter 16) with a view to identifying successful treatment models and expanding these programs to improve access and reduce wait times.

That the provinces and territories develop and implement evidence-based outreach, and primary and secondary prevention programs for at-risk populations — women, children and youth, seniors, and those affected by Fetal Alcohol Spectrum Disorders.

Recommendation 44 (page 219):

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

That family physicians be trained, through medical school and professional development curricula, on diagnostic guidelines for Fetal Alcohol Spectrum Disorders (FASD).

That family physicians be trained in the use of brief intervention and interview techniques to recognize problem substance use leading to addiction.

Recommendation 45 (page 225):

That the Canadian Mental Health Commission (see Chapter 16) actively partner with national addiction organizations, and work toward the eventual goal of integration of the addiction and mental health sectors.

CHAPTER 10: SELF-HELP AND PEER SUPPORT

Recommendation 46 (page 233):

That programs be put in place to develop leadership capacity among persons living with mental illness, and their families.

That the Knowledge Exchange Centre (see Chapter 16) contribute to building this capacity by facilitating electronic access to information and technical assistance for people affected by mental illness and their families.

Recommendation 47 (page 237):

That funding be made available through the Mental Health Transition Fund (see Chapter 16) that is specifically targeted at:

- Increasing the number of paid peer support workers in community-based mental health service organizations.
- Providing stable funding to strengthen existing peer development initiatives, build new initiatives (including family groups), and build a network of self-help and peer support initiatives throughout the country.

That the federal government lead by example, building on innovations such as the National Peer Support Program for current and former Canadian Forces members and support, with appropriate levels of funding, self-help and peer support programs for the client groups that fall under the jurisdiction of the federal government.

Recommendation 48 (page 238):

That research be undertaken to:

- quantify the benefits of self-help and peer support to participants,
- identify savings to the health care system that result from peer support initiatives, and

That a portion of these savings be redirected to support further self-help and peer support initiatives.

Recommendation 49 (page 239):

That the Canadian Institutes of Health Research (CIHR) support research into self-help and peer support, and that in determining which research projects to fund the CIHR utilize a review process that welcomes and understands the types of participatory methodologies that persons living with mental illness, and their families, prefer and find effective.

Recommendation 50 (page 242):

That accountability measures for mental health and addiction services include not just process issues such as numbers of visits, hours of counselling or dollars spent, but also address outcomes, such as respect, preservation of dignity, as well as a focus on hope and recovery, since these figure amongst the things that persons living with mental illness, and their families, value most.

Recommendation 51 (page 245):

That accountability requirements that are established for self-help and peer support groups do not impose an overly onerous burden on these groups, and that measures be taken to ensure that these groups are able to meet these requirements.

That consumer and family-led certification and accreditation processes for self-help and peer support programs be developed and funded to ensure quality, and to sustain the unique contribution of self-help and peer support initiatives.

Recommendation 52 (page 247):

That existing and new consumer and family organizations be funded at an annualized, sustainable level.

That broad-based coalitions be funded and built among self-help and peer support organizations so that they do not continue to exist in isolation but are able to form networks with one another.

CHAPTER 11: RESEARCH, ETHICS AND PRIVACY

Recommendation 53 (page 256):

That the Canadian Mental Health Commission (see Chapter 16) work with non-governmental health organizations to develop and strengthen their fundraising capacities in order to raise more funds for research on mental health and addiction.

Recommendation 54 (page 257):

That the Canadian Institutes of Health Research actively seek out more opportunities for research partnerships on mental health and addiction with the private and not-for-profit sector.

Recommendation 55 (page 257):

That the Canadian Institutes of Health Research formalize the involvement of non-governmental health organizations, persons living with mental illness and family members in the setting of mental health research priorities and participation in peer review panels.

Recommendation 56 (page 259):

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

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

That this \$25 million be incremental to the funding currently provided to the CIHR.

Recommendation 57 (page 260):

That the Government of Canada, within a reasonable time frame, increase its funding to health research to achieve the level of 1% of total health care spending.

Recommendation 58 (page 259):

That the Canadian Institutes of Health Research, through the Institute of Neurosciences, Mental Health and Addiction, increase the funds available specifically for recruiting and training researchers and for clinical research on mental health, mental illness and addiction issues.

Recommendation 59 (page 262):

That the Knowledge Exchange Centre to be created by the Canadian Mental Health Commission (see Chapter 16) incorporate, amongst other things, an Internet-based database of research funding agencies and funding opportunities, identify what research is being conducted and where, and include summaries of research findings from all levels of government, universities, and non-governmental organizations.

That the Knowledge Exchange Centre also assist in the exchange of information by organizing conferences, workshops, and training sessions on mental health research.

Recommendation 60 (page 264):

That the Canadian Institutes of Health Research (CIHR), through the Institute of Neurosciences, Mental Health and Addiction, substantially increase its efforts in knowledge translation in relation to mental health, mental illness and addiction research.

That CIHR work closely with the proposed Knowledge Exchange Centre in order to facilitate knowledge exchange among decision-makers, providers and consumer groups.

Recommendation 61 (page 266):

That the Canadian Institutes of Health Research, through the Institute of Neurosciences, Mental Health and Addiction, work closely with the Canadian Mental Health Commission (see Chapter 16), researchers, provincial and non-governmental research funding agencies, and organizations representing people living with mental illness or addictions in order to develop a national research agenda on mental health, illness and addiction.

Recommendation 62 (page 268):

That the Public Health Agency continue its efforts to develop in a timely way a comprehensive national mental illness surveillance system that incorporates appropriate privacy provisions.

That the Public Health Agency expand the range of data collected in cooperation with other agencies, such as the Canadian Institute for Health Information and Statistics Canada, as well as other levels of government and organizations that collect relevant data.

That, as it develops a comprehensive national mental health surveillance system, the Public Health Agency work with the Canadian Mental Health Commission (see Chapter 16).

Recommendation 63 (page 271):

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

CHAPTER 12: TELEMENTAL HEALTH IN CANADA

Recommendation 64 (page 279):

That the provinces and territories work together to put in place licensing agreements and reimbursement policies that will allow for the development of telemental health initiatives across the country.

That the Canadian Mental Health Commission (see Chapter 16) work with the provinces and territories to identify and resolve any outstanding licensing and reimbursement issues.

Recommendation 65 (page 280):

That telemental health initiatives be eligible for funding through the Mental Health Transition Fund (see Chapter 16).

Recommendation 66 (page 280):

That the funding agreement between Canada Health Infoway and the Government of Canada be revised so that Canada Health Infoway is no longer limited to being able to cover only up to 50% of eligible costs of telehealth projects and is allowed to establish the same ratio for its investments in telehealth projects as it uses in other projects.

Recommendation 67 (page 281):

That the Knowledge Exchange Centre (see Chapter 16) work with the provinces and territories, as well as with other bodies such as the Canadian Institute for Health Information, in order to measure the cost-effectiveness of telemental health care delivery compared to traditional mental health service delivery.

That the Knowledge Exchange Centre assist in the development of evaluation tools for telemental health services.

Recommendation 68 (page 282):

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

CHAPTER 13: THE FEDERAL DIRECT ROLE

13.1 FIRST NATIONS AND INUIT

Recommendation 69 (pages 297-298):

That the federal government establish a federal entity for First Nations and Inuit clients, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee;

That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of First Nations and Inuit;

That the person responsible for this entity be, if possible, of aboriginal origin;

That this entity provide an annual report to Parliament.

Recommendation 70 (page 298):

That Indian and Northern Affairs Canada, Health Canada and any other departments with direct program and service responsibility for First Nations and Inuit clients develop an annual inventory of their respective programs and services currently and for the last five years.

That the inventory include a clear description of: each program or service by fiscal year; the criteria for eligibility; the number of First Nations and Inuit clients respectively served by the program by geographical location; the amount of funding allocated and the amount spent; and any evaluation of outcomes related to the determinants of mental health.

That the inventory be reported to Parliament annually starting in 2008.

Recommendation 71 (page 300):

The federal government immediately establish an independent study into the federal provision of programs and services relevant to the overall health of First Nations and Inuit;

That this study examine various alternatives for the provision of these services; provide clear assessments of these alternatives; and present a comprehensive report with recommendations to Parliament in 2008.

13.2 FEDERAL OFFENDERS

Recommendation 72 (page 312):

That Correctional Service Canada (CSC) develop and implement standard of care guidelines for mental health to be applied within institutions and in post-release settings that are equivalent to those applied in settings accessed by the general population.

That CSC guidelines be based on the collection of statistical information about federal offenders and their mental health disorders and addictions, including prevalence rates for mental health disorders, type of treatment utilized (psychotherapy, medication, etc.), rate of hospitalization, etc.

That CSC performance with respect to implementing the guidelines be reviewed annually by an independent external body with mental health expertise such as the Canadian Mental Health Commission (see Chapter 16).

That data used for the guidelines be compiled and made available to the public and that the raw data be made available to researchers for independent analysis.

That the performance assessment be reported to Parliament annually starting in 2008.

Recommendation 73 (page 313):

That Correctional Service Canada conduct a full clinical assessment by an accredited mental health professional of each offender to determine their mental health and/or addiction treatment needs to be completed no later than seven calendar days after their arrival at a reception centre.

That Correctional Service Canada undertake training of correctional officers and other staff immediately following their appointment to enable them to distinguish between a mental health crisis and a security crisis.

That Correctional Service Canada make psychotherapy available to offenders, when medically necessary, provided by a psychiatrist, psychologist, clinical social worker or other health care professional who is not responsible for the risk assessment of offenders.

That Correctional Service Canada increase the capacity of its existing treatment centres with additional beds as well as additional staff.

That Correctional Service Canada immediately implement expanded harm reduction measures in all federal correctional institutions.

Recommendation 74 (page 313):

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

13.3 CANADIAN FORCES

Recommendation 75 (page 321):

That National Defence develop an annual inventory of its programs and services for mental health;

That the inventory include a clear description of each program or service with number of clients served, the amount of funding allocated and spent, and any evaluation of outcomes achieved;

That the inventory be reported to Parliament annually starting in 2008.

Recommendation 76 (page 322):

That National Defence require that all medical personnel receive mandatory training with respect to operational stress injury and that this training include:

- proper recording of military and trauma histories;
- methods to recognize/detect symptoms of operational stress injury;
- understanding of multiple treatment modalities; and

- appropriate long-term follow-up processes;

That National Defence make the information available to National Defence and civilian medical personnel through publications, seminars, or other public forums;

That National Defence explore measures to encourage more widespread use of peer counselling and increased engagement of family and community.

Recommendation 77 (page 323):

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

13.4 VETERANS

Recommendation 78 (page 332):

That Veterans Affairs Canada in conjunction with National Defence prepare an annual inventory of programs and services for mental health, including the number of clients served, the funding allocated and spent, and the outcomes achieved.

That the report be tabled in Parliament annually starting in 2008.

Recommendation 79 (page 332):

That the Government of Canada establish an entity for veterans, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee;

That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of veterans;

That this entity provide an annual report to Parliament.

13.5 ROYAL CANADIAN MOUNTED POLICE

Recommendation 80 (page 338):

That the federal government fund a mental health and addictions training program aimed at RCMP members.

That the RCMP make public as soon as possible in 2006 the results of the ongoing analysis by the RCMP task force looking at RCMP disability and the need for programs and services.

That the RCMP establish the use of peer counselling for RCMP members following the DND/VAC model for post-traumatic stress.

That the RCMP include these initiatives and other programs and services in an annual inventory on programs and services for RCMP officers.

That the inventory be reported to Parliament annually starting in 2008.

Recommendation 81 (page 339):

That the RCMP External Review Committee do an analysis of the mental health needs of RCMP members and RCMP veterans and report to Parliament by 2007.

13.6 IMMIGRANTS AND REFUGEES

Recommendation 82 (page 346):

That the federal government establish an entity for immigrants and refugees, similar to the Correctional Investigator, the Canadian Forces Ombudsman, or the RCMP External Review Committee;

That this entity be authorized to investigate individual complaints as well as systemic areas of concern related to federal provision of programs and services that have an impact on the mental wellbeing of immigrants and refugees;

That this entity provide an annual report to Parliament.

Recommendation 83 (page 346):

That Citizenship and Immigration Canada provide an annual inventory to Parliament on its programs and services relevant to mental health, including clients served, expenditures allocated and spent, and outcomes achieved, starting in 2008.

That Citizenship and Immigration Canada increase funding for and access to language training by diverse groups through increased training allowances, appropriate scheduling of instructional hours, and the location of classes in places that facilitate access.

13.7 FEDERAL PUBLIC SERVICE EMPLOYEES

Recommendation 84 (pages 352-353):

That the federal government draw upon the model established by the Global Business and Economic Roundtable on Addiction and Mental Illness in coordinating interdepartmental mental health policies, programs and activities for employees.

That the federal government, as an employer, form a partnership with other sectors and jurisdictions, including the Global Business and Economic Roundtable on

Addiction and Mental Health, to stimulate and facilitate the exchange of best practices in the support of workplace wellbeing and better employee mental health.

That, as it develops strategies to support mental health in its workforce, the federal government place a specific emphasis on measures that will reduce and eventually eliminate the stigma attached to mental illness.

Recommendation 85 (page 353):

That the Public Service Human Resources Management Agency conduct annual evaluations of the federal government's provision of policies, programs, and activities designed to support mental health in the public service;

That these evaluations be based on clear performance indicators that include the use of surveys to assess employee satisfaction;

That the evaluations be used as a basis for adjustments to policies, programs, and activities in order to better suit them to the needs of employees;

That results of these evaluations, and the adjustments that were made based upon them, be reported to Parliament on an annual basis starting in 2008.

13.8 TOWARDS A FEDERAL GOVERNMENT STRATEGY FOR FEDERAL CLIENTS

Recommendation 86 (page 354):

That the federal government develop a strategy for mental health that is inclusive of all federal client groups and that takes into account each group's particular needs;

That the strategy set goals, including a timetable for implementation and for subsequent evaluation;

That the strategy have as its objective making the federal government a model employer as well as model provider with respect to its various clients.

Recommendation 87 (page 355):

That the mental health strategy to be developed by the federal government incorporate a population health approach to the determinants of mental health, and that it specifically address the economic, educational, occupational and social factors that have an impact on the mental health of all federal clients;

That the federal government report to Parliament in 2008 on what precisely it is doing to implement a population health approach for federal clients.

Recommendation 88 (page 356):

That the federal government immediately develop and implement an anti-stigma campaign for all federal client groups.

Recommendation 89 (pages 356-357):

That the federal government establish a central coordinating mechanism for the development and delivery of mental health policies, programs, and activities across its departments and agencies;

That this federal body work with the Correctional Investigator, the Canadian Forces Ombudsman, and the RCMP External Review Committee and other similar entities to be established by departments to ensure that the needs of individual client groups are being addressed;

That this federal body coordinate and monitor the work of these individual entities in investigating and getting responses to concerns about mental health services for each federal client group;

That this federal body provide an annual report to Parliament.

Recommendation 90 (page 359):

That the federal government immediately undertake an assessment of all of its insurance plans for all federal clients to determine their applicability and effectiveness;

That this assessment include a comparative evaluation of benefits, of coverage for specific mental health, mental illness and addiction needs, of administrative costs, and of results achieved under the various insurance plans;

That this review of insurance plans be reported to Parliament in 2008.

Recommendation 91 (page 360):

That all federal departments with direct program and service responsibility for specific client groups — including First Nations and Inuit, federal offenders, immigrants and refugees, veterans, Canadian Forces, RCMP, and federal public service employees — develop an annual report that includes a description of federal responsibility, federal programs and services, and the extent to which these meet the mental health needs of clients;

That this annual report include an annual inventory of their current respective programs and services as well as a three-year comparison;

That the inventory include a clear description for each program or service by fiscal year of the criteria for eligibility, of the number of clients served by the program, of the amount of funding allocated and the amount spent, as well as an evaluation of outcomes related to the determinants of mental health;

That the inventory be tabled in Parliament annually starting in 2008.

CHAPTER 14: ABORIGINAL PEOPLES OF CANADA

Recommendation 92 (page 363)

That the Canadian Mental Health Commission (see Chapter 16) establish an Aboriginal Advisory Committee comprised of representatives of Aboriginal communities, whose membership shall be determined by the Commission in consultation with Aboriginal organizations, and shall provide representation from First Nations, Inuit and Métis and broadly reflect the geographic distribution of Aboriginal communities across the country.

Recommendation 93 (page 370):

That, as a priority, the Canadian Mental Health Commission (see Chapter 16), with the full involvement of its Aboriginal advisory committee, develop a strategy for mental health wellness and healing among Aboriginal peoples.

That the strategy set goals, including a timetable for implementation, and recommend ways to evaluate outcomes.

That the strategy adopt distinct approaches for First Nations, Inuit and Métis.

Recommendation 94 (page 376):

That the Canadian Mental Health Commission (see Chapter 16), in consultation with its Aboriginal advisory committee, develop, as an integral component of the wellness and healing strategy for mental health, a plan that would:

- identify key health determinants;
- assess the influence of these determinants on mental health;
- detail measures for implementation; and
- establish timelines and funding levels needed to promote wellness and healing.

Recommendation 95 (pages 381-382):

That the Government of Canada create an interdepartmental committee composed of deputy ministers in departments with responsibility for Aboriginal peoples, chaired by the Privy Council Office.

That the interdepartmental committee prepare a report to be tabled in Parliament every two years on the impact of the work of these departments on the wellness of Aboriginal peoples, including but not limited to their mental wellness.

That this Aboriginal wellness report include an inventory of all federal programs and services specific to each group of Aboriginal peoples, with information on spending and the impact on actual health outcomes achieved, including but not limited to mental health outcomes.

That the interdepartmental committee support working groups composed of First Nations, Inuit and Métis representatives to provide information, advice and verification of the report.

Recommendation 96 (pages 388-389):

That the Government of Canada work closely with the provinces/territories and representatives from the different Aboriginal communities to develop programs and services deemed necessary by Aboriginal peoples.

That criteria for the design and delivery of identified programs and services take into account the importance of enhancing community involvement, and of ensuring cultural accommodation and equity of access.

That any delivery mechanism for these programs and services include ongoing oversight and public evaluation of outcomes by the funding body.

That the criteria for funding and accountability provisions be made public.

Recommendation 97 (page 391):

That the Government of Canada renew the mandate of the Aboriginal Healing Foundation and provide funding for another three years.

That, on a priority basis, the Canadian Mental Health Commission (see Chapter 16) and its Aboriginal advisory committee undertake an evaluation of the efficiency and effectiveness of the Aboriginal Healing Foundation.

That the results of the assessment include recommendations concerning the future of the Aboriginal Healing Foundation and be made public.

Recommendation 98 (pages 394-395):

That the Government of Canada work with the provinces and with universities and colleges to establish clear targets for Aboriginal health human resources.

That the Government of Canada finance specific access for Aboriginal students seeking careers in mental health.

That the Government of Canada increase its financial and social support for Aboriginal students engaged in these studies.

Recommendation 99 (page 398):

That the Canadian Mental Health Commission (see Chapter 16), as a high priority, identify measures to reduce the alarming suicide rates amongst Aboriginal peoples.

That identification of these measures be a component of its priority action on an Aboriginal wellness and healing strategy.

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

That the fund include specific allocations for implementing any measures identified by the Canadian Mental Health Commission as well as for increased research by the

Canadian Institutes of Health Research and for specific data collection by the Canadian Institute for Health Information in collaboration with the National Aboriginal Health Organization.

Recommendation 100 (page 400):

That the Canadian Mental Health Commission (see Chapter 16) identify measures to reduce the alarming alcohol and substance addiction rates amongst Aboriginal peoples.

That identification of these measures be a component of its priority action on an Aboriginal wellness and healing strategy.

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

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

Recommendation 101 (page 403):

That the Government of Canada work with the National Aboriginal Health Organization to assess the appropriateness of the First Nations regional health survey for use as a model for data collection for other Aboriginal peoples.

That the Canadian Institute for Health Information be encouraged to provide analysis of health determinants data related to each of the Aboriginal peoples.

That the Canadian Mental Health Commission (see chapter 16) work with the Canadian Institute for Health Information to improve understanding of mental health causes and outcomes.

Recommendation 102 (page 407):

That the Government of Canada undertake immediate analyses of the current level of federal funding for Aboriginal peoples.

That the analyses assess how much funding would be required to change key health determinants for Aboriginal peoples.

That the analyses include a short, medium and long range assessment for funding needs.

That the first report to Parliament by the inter-departmental committee recommended in section 14.6.3 include the results of the analyses.

CHAPTER 15: MENTAL HEALTH PROMOTION AND DISORDER PREVENTION

Recommendation 103 (page 421):

That mental health be included as an immediate priority health issue in the Integrated Pan-Canadian Healthy Living Strategy.

Recommendation 104 (page 421):

That the Public Health Agency of Canada, in collaboration with other stakeholders, prepare a Mental Health Guide for Canadians and ensure its broad distribution.

Recommendation 105 (page 423):

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

That all mental health promotion and mental illness prevention initiatives contain provisions for monitoring and evaluating their impact.

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

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

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

Recommendation 106 (page 427):

That the federal government support the efforts of the Canadian Association for Suicide Prevention and other organizations working to develop a national suicide prevention strategy.

That the Canadian Mental Health Commission (see Chapter 16) work closely with all stakeholders to, among other things:

- develop consistent standards and protocols for collecting information on suicide deaths, non-fatal attempts and ideation;
- increase the study and reporting of risk factors, warning signs and protective factors for individuals, families, communities and society;
- support the development of a national suicide research agenda along the lines proposed by the Canadian Institutes of Health Research.

CHAPTER 16: NATIONAL MENTAL HEALTH INITIATIVES

Recommendation 107 (pages 445-446):

That a Canadian Mental Health Commission be established and that it become operational by 1 September 2006.

That the guiding principles, mandate, method of operation and activities of the Canadian Mental Health Commission be as specified in sections 16.2.2 to 16.2.5 of this report.

That the composition of the Board of the Commission and its staff be established as set out in sections 16.2.6 and 16.2.7 of this report.

That the Government of Canada provide \$17 million per annum to fund the operation and activities of the Commission; of this amount, \$5 million per annum should be dedicated to a national anti-stigma campaign, \$6 million per annum devoted to the creation of the Knowledge Exchange Centre and \$6 million per annum used to cover the operating costs of the Commission.

Recommendation 108 (pages 456-457):

That the Government of Canada create a Mental Health Transition Fund in order to help accelerate the transition to a system in which the delivery of mental health services and supports is based predominantly in the community.

That this Fund be made available to the provinces and territories on a per capita basis, and that the Fund be administered by the Canadian Mental Health Commission that has been agreed to by all Ministers of Health (with the exception of Quebec).

That the provinces and territories be eligible to receive funding from the Mental Health Transition Fund for a Basket of Community Services, as long as these projects:

- Would not otherwise have been funded; that is, these projects would represent an increase in provincial or territorial spending on mental health services that is over and above existing spending on services and supports plus an increment equal to the annual percentage increase in overall spending on health;
- Contribute to the transition towards a system in which the delivery of mental health services and supports is based predominantly in the community.

That, as part of the Mental Health Transition Fund, the Government of Canada create a Mental Health Housing Initiative that will provide funds both for the development of new affordable housing units and for rent supplement programs that subsidize people living with mental illness who would otherwise not be able to rent vacant accommodation at current market rates.

- That, in managing the housing portion of the Mental Health Transition Fund, the Canadian Mental Health Commission should work closely with the Canada Mortgage and Housing Corporation.

Recommendation 109 (page 458):

That the territories receive additional funding from the federal government, over and above their per capita allocation from the Mental Health Transition Fund, in order to assist them in addressing the needs of remote, isolated and non-urban communities.

Recommendation 110 (page 459):

That the use of the monies from the Mental Health Transition Fund should be subjected to an external audit, to be performed by provincial auditors general in order to ensure that the monies are spent in a manner consistent with the two objectives of the Transition Fund, namely:

- (a) to fund community based mental health services and supports; and
- (b) to increase the total amount each jurisdiction spends on enhancing mental health and treating mental illness.

Recommendation 111 (page 461):

That the Basket of Community Services component of the Mental Health Transition Fund average \$215 million per year over a ten year period, for a total of \$2.15 billion.

Recommendation 112 (pages 465-466):

That the Government of Canada invest \$2.24 billion over ten years in the Mental Health Housing Initiative (MHHI) that is to be established as part of the Mental Health Transition Fund.

That the MHHI have as its goal to reduce the percentage of Canadians living with mental illness in need of housing that is adequate, suitable and affordable from 27% to the national average (15%) of people in need of such housing, specifically by providing 57,000 people living with mental illness with access to affordable housing.

That, over the life of the MHHI, 60% of its funds be allocated to providing rent supplements to people living with mental illness who would otherwise be unable to afford to rent accommodation at market rates, and the remaining 40% be devoted to the development of new affordable housing units.

That, in order to provide immediate assistance to as many people as possible, during the first three years of the MHHI, fully 80% of available funds be allocated to rent supplements; and that during this period the federal government pay the full share of the rent subsidies, after which the cost of the rent subsidies be shared according to existing federal-provincial-territorial arrangements.

That innovative approaches by governments, health authorities and non-profit organizations be supported, such as aggregation of subsidies to allow partnerships with tenants in the purchase of housing properties.

That, following the ten-year life of the MHHI, the Canada Mortgage and Housing Corporation be mandated to maintain the percentage of people living with mental illness who are in need of housing that is adequate, suitable and affordable at the same percentage as that of the population as a whole.

Recommendation 113 (page 469):

That the Government of Canada include as part of the Transition Fund \$50 million per year to be provided to the provinces and territories for outreach, treatment, prevention programs and services to people living with concurrent disorders. As with the rest of the Transition Fund, this money would be managed by the Canadian Mental Health Commission, but in respect of this component of the fund there should be close consultation with the Canadian Centre for Substance Abuse, as well as the provinces, territories, and other stakeholders.

Recommendation 114 (page 470):

That the Government of Canada provide the provinces and territories with \$2.5 million per year to help them move forward with their plans for telemental health. This money would be part of the Mental Health Transition Fund and be administered by the Canadian Mental Health Commission.

Recommendation 115 (page 470):

That the Government of Canada provide the provinces and territories with \$2.5 million per year for peer support and self-help initiatives. This money would be part of the Mental Health Transition Fund and be administered by the Canadian Mental Health Commission.

Recommendation 116 (page 471):

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

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

That this \$25 million be incremental to the funding currently provided to the CIHR.

Recommendation 117 (page 473):

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

Recommendation 118 (page 473):

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

**APPENDIX B:
LIST OF WITNESSES⁴²⁷
-FIRST SESSION OF THE 38TH PARLIAMENT
(OCTOBER 4, 2004 — NOVEMBER 29, 2005)**

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Aboriginal Healing Foundation	Dr. Gail Valaskakis, Director of Research	Sept. 20, 2005	23
		June 21, 2005	27
Aboriginal Survivors for Healing	Tarry Hewitt, Project Coordinator	June 16, 2005	22
Abri en Ville (L')	Audrey Bean, President	June 21, 2005	23
Across Boundaries, Ethnoracial Mental Health Care	Martha Ocampo, Co-director	Feb. 17, 2005	7
Addictions Foundation of Manitoba	John Borody, Chief Executive Officer	May 31, 2005	16
	Jim Robertson, Chairman of the Board		
Alberta Alcohol and Drug Abuse Commission	Bill Bell, Director of Residential Services	June 9, 2005	21
	Murray Finnerty, Chief Executive Officer		
	Dave Rodney, MLA Chair		
Alberta Alliance on Mental Illness and Mental Health	George Lucki, Chair	June 9, 2005	21
Alberta Mental Health Board, Wisdom Committee	Gloria Laird, Co-Chair	June 9, 2005	21
	Sykes Powderface, Co-Chair		
Alberta Mental Health Board	Elsie Bastien, Aboriginal Liaison Coordinator	June 9, 2005	21
	Sharon Steinhauer, Board Member		
Alberta Mental Health Self Help and the National Network for Mental Health	Carmela Hutchinson, President	June 9, 2005	21

⁴²⁷ The Committee proceedings from the First Session of the 38th Parliament are available at:
http://www.parl.gc.ca/common/Committee_SenProceed.asp?Language=E&parl=38&Ses=1&comm_id=47

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Alcohol and Drug Recovery Association of Ontario (ADRA) and Addiction Intervention Association	Jeff Wilbee, Executive Director	Sept. 21, 2005	28
Alliance for Mental Illness and Mental Health in Manitoba	Carol Hiscock, Member	May 31, 2005	16
Alzheimer Society-Nova Scotia	Menna MacIssac, Director, Program and Operations	May 10, 2005	15
As an Individual	Bonita Allan	June 6, 2005	18
As an Individual	Francesca Allan	June 6, 2005	18
As an Individual	Lionel Berger	Feb. 16, 2005	6
As an Individual	Edouardine Boudreau	May 11, 2005	15
As an Individual	Monette Boudreau	May 11, 2005	15
As an Individual	Lembie Buchanan	Feb. 16, 2005	6
As an Individual	Pat Capponi	Feb. 15, 2005	5
As an Individual	Geraldine Cardinal	June 9, 2005	21
As an Individual	Richard Casey	Feb. 15, 2005	5
As an Individual	Barbara Chatelain	June 1, 2005	16
As an Individual	Raymond Cheng	Feb. 17, 2005	7
As an Individual	Graham Crushing	Feb. 15, 2005	5
As an Individual	Michèle Dawson	June 21, 2005	23
As an Individual	Harold Dunne	June 14, 2005	22
As an Individual	Roslyn Durdy	Feb. 15, 2005	5
As an Individual:	Louise Elliott	Feb. 16, 2005	6
As an Individual	Ron Fitzpatrick	June 14, 2005	22
As an Individual	Helen Forristall	June 14, 2005	22
As an Individual	Phyllis Grant-Parker	Feb. 16, 2005	6
As an Individual	Julie Haubrich	Feb. 16, 2005	6
As an Individual	Donna Huffman	June 1, 2005	16
As an Individual	Deborah Jackman	June 14, 2005	22
As an Individual	Ruth Johnson	June 6, 2005	16-18

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
As an Individual	Sister Johanna Jonker	June 1, 2005	16
As an Individual	Honourable Judge Douglas Carruthers	Feb. 16, 2005	6
As an Individual	Honourable Judge Richard D.Schneider,	Feb. 16, 2005	6
As an Individual	Susan Kilbridge-Roper	May 9, 2005	15
As an Individual	Charles Leblanc	May 11, 2005	15
As an Individual	George MacDonald	May 9, 2005	15
As an Individual	Gail MacLean	June 16, 2005	22
As an Individual	Adrienne Magennis	Feb. 15, 2005	5
As an Individual	Rafe K.Mair	June 8, 2005	19
As an Individual	Roman Marshall	May 31, 2005	16
As an Individual	Tara Marttinen	Feb. 16, 2005	6
As an Individual	Carolyn Mayeur	Feb. 15, 2005	5
As an Individual	Rona Maynard	Feb. 16, 2005	6
As an Individual	Neil McQuaid	Feb. 15, 2005	5
As an Individual	Sheila Morrison	May 9, 2005	15
As an Individual	Roy Muise	May 9, 2005	15
As an Individual	Chief Susan Levy Peters	May 11, 2005	15
As an Individual	Darrell C.Powell	Feb. 15, 2005	5
As an Individual	Doris Ray	June 6, 2005	18
As an Individual	Gregg Reddin	June 16, 2005	22
As an Individual	Dr. Ian Reid	June 16, 2005	22
As an Individual	David Reville	Feb. 15, 2005	5
As an Individual	Sven Robinson	June 7, 2005	19
As an Individual	Robert J. Ryan	June 14, 2005	22
As an Individual	Sandra Schwartz	Feb. 16, 2005	6
As an Individual	Scott Simmie	Feb. 16, 2005	6
As an Individual	Richard Smith	Feb. 15, 2005	5

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
As an Individual	Morra Stewart	Feb. 16, 2005	6
As an Individual	Allan Strong	Feb. 15, 2005	5
As an Individual	Joyce Taylor	May 9, 2005	15
As an Individual	Sheila Wallace-Hayes	May 9, 2005	15
As an Individual	Don Weitz	Feb. 16, 2005	6
As an Individual	Norrah Whitney	Feb. 15, 2005	5
As an Individual	Rob Wipond	June 6, 2005	18
Assembly of First Nations	Dr. Valérie Gideon, Director of Health and Social Secretariat	Sept. 20, 2005 June 21, 2005	23 27
	Chief A-in-chut (Shawn Atleo, BC Regional Chief)	Sept. 20, 2005	23
	Chief Norman Bone	May 31, 2005	16
Chief Ron Evans			
Christina Keeper, Suicide Prevention Envisioning Team	June 1, 2005		
Irene Linklater, Research Director, Research & Policy Development Unit			
Kathleen McKay, Youth Council	May 31, 2005		
Amanda Meawasige, Youth Council			
Gwen Wasicuna, Youth Council			
Jason Whitford, Coordinator, Youth Council			
Atlantic Association of Addiction Executives:	Greg Purvis, Chair	Sept. 21, 2005	28
Au coeur des familles agricoles	Maria Labrecque-Duchesneau, Director General	June 21, 2005	23
BC Alliance for Accountable Mental Health and Addictions Services	John Russell, Chair	June 7, 2005	19
Bluewater District School Board	Michelle Forge, Superintendent of Student Services	May 6, 2005	14

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
British Columbia Psychogeriatric Association	Penny MacCourt, Board Member and Past President	June 8, 2005	20
Brock University	Richard C. Mitchell, Faculty Member and Researcher at the Department of Child and Youth Studies	May 6, 2005	14
Canadian Agriculture Safety Association	Marcel Hacault, Executive Director	June 1, 2005	16
	Kim Moffat, Councilor, Manitoba Farm and Rural Stress Line		
Canadian Agriculture Safety Association	Janet Smith, Manager of the Manitoba Farm and Rural Stress Line	June 1, 2005	16
Canadian Alliance on Mental Illness and Mental Health	Phil Upshall, Executive Director	April 21, 2005	13
	Dr. John Service, Chair		
Canadian Association for Suicide Prevention	Paul Links, President, Professor of Psychiatry, University of Toronto	Feb. 17, 2005	7
Canadian Association of Elizabeth Fry Societies	Kim Pate, Executive Director	Feb. 16, 2005	6
Canadian Coalition for Senior's Mental Health	Faith Malach, Executive Director	June 8, 2005	20
Canadian Collaborative Mental Health Initiative:	Dr. Nick Kates, Chair	Feb. 17, 2005	7
Canadian Medical Association	Dr. Albert Schumacher, President	April 20, 2005	13
	Dr. Isra Levy, Chief Medical Officer and Director, Office for Public Health		
Canadian Mental Health Association	Penelope Marrett, Chief Executive Director	April 20, 2005	13
Canadian Mental Health Association – Newfoundland and Labrador Division	Geoff Chaulk, Executive Director	June 15, 2005	22

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Canadian Mental Health Association – Nova Scotia Division	Carole Tooton, Executive Director	May 9, 2005	15
Canadian Mental Health Association – Toronto Branch	Steve Lurie, Executive Director	Feb. 17, 2005	7
Canadian Mental Health Association (P.E.I.) Support Needs Working Group	Bonnie Arnold, Associate Executive Director	June 16, 2005	22
Canadian Mental Health Association, Alberta Division	Peter Portlock, Executive Director	June 9, 2005	21
Canadian Mental Health Association, British Columbia Division	Bev Gutray, Executive Director	June 6, 2005	18
Canadian Mental Health Association, New Brunswick Division	Armand Savoie, President	May 11, 2005	15
Canadian Mental Health Association, Saskatchewan Division	David Nelson, Executive Director	June 2, 2005	17
Canadian National Committee for Police/Mental Health Liaison	Dr. Dorothy Cotton, Co-Chair, Psychologist	Feb. 16, 2005	6
Canadian Nurses Association	Christine Davis, President, Canadian Federation of Mental Health Nurses	April 20, 2005	13
Canadian on Substance Abuse	Michel Perron, Chief Executive Officer	Sept. 21, 2005	28
	Dr. John Weekes, Senior Research Analyst		
Canadian Paediatric Society	Dr. Diane Sacks, Past President	April 20, 2005	13
Canadian Psychiatric Association	Dr. Blake Woodside, President	April 20, 2005)	13
Canadian Psychological Association	John Arnett, President	April 20, 2005)	13
Capital District Health Authority	Stephen Ayr, Director of Research	(May 9, 2005)	15
Centre de recherche et d'intervention sur le suicide et l'euthanasie – Université du Québec à Montréal	Sylvaine Raymond, Research Co-ordinator	July 5, 2005	25

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Centre for Aboriginal Health Research, University of Manitoba	Dr. Javier Mignone, Research Associate	June 1, 2005	16
Centre for Addiction and Mental Health	Jennifer Barr, Education and Publishing Consultant	June 8, 2005	20
	Diana Capponi	Feb. 15, 2005	5
	Margaret C Flower, Clinical Counsellor	June 8, 2005	20
	Betty Miller, Coordinator of Family Council	Feb. 15, 2005	5
	Wayne Skinner, Clinical Director, Concurrent Disorders Programs	Sept. 21, 2005	28
Centre for Addictions Research of BC, University of Victoria	Tim Stockwell, Director	Sept. 21, 2005	28
Children's Hospital of Eastern Ontario	Dr. Simon Davidson, Chief of Staff	May 6, 2005	14
	Dr. Ian Manion, Psychologist		
Citizenship and Immigration Canada	Dr. Sylvie Martin, Acting Director, Immigration Health Program Elaboration	Feb. 23, 2005	8
Coast Foundation Society/Coast Mental Health Foundation	Darrell J. Burnham, Executive Director	June 6, 2005	18
College of Registered Psychiatric Nurses of Manitoba	Dawn Bollman, President	May 31, 2005	16
	Annette Osted, Executive Director		
Commission des droits de la personne et des droits de la jeunesse	Lucie France Dagenais, Researcher	July 5, 2005	25
Commission for Public Complaints against the RCMP	Shirley Heafey, Chair	May 10, 2005	15
Community Health Sciences, University of Calgary	Jian Li Wang, Associate Professor, Psychiatry	July 5, 2005	25
Connections Clubhouse	Nancy Beck, Director	May 9, 2005	15
Consumer/Survivor Information Resource Centre	Helen Hook, Coordinator	Feb. 15, 2005	5

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Consumers Health Awareness Network Newfoundland and Labrador (CHANNAL)	Joan Edwards-Karmazyn, Manager	June 14, 2005	22
Correctional Service Canada	Brian Grant, Director, Addictions Research Centre	Sept. 21, 2005	28
Crisis Intervention and Suicide Prevention Centre of British Columbia	Ian Ross, Executive Director	June 7, 2005)	19
Dalhousie University	Dr. Richard Goldloom, Professor of Pediatrics; Member of the Consulting staff at the Nova Scotia Rehabilitation Centre	May 6, 2005	14
	Archibald Kaiser, Professor, Faculty of Law, Department of Psychiatry, Faculty of Medicine	May 10, 2005	15
	Patrick MacGrath, Canada Research Chair in Pediatric Pain	May 10, 2005	15
	Dr. Aidan Stokes, Acting Head, Department of Psychiatry	May 9, 2005	15
Departement of Health of Nova Scotia, Mental Health Services Branch	John Campbell, Director of Adult Mental Health Services	May 9, 2005	15
	Linda Smith, Acting Executive Director, Children's Mental Health Services and Addictions Treatment		
Department of Health and Wellness of New Brunswick	Barbara Whitenect, Acting Director of Child & Youth Services	May 6, 2005	14
Depression and Manic Depression Support Group Regina	Frank Dyck	June 2, 2005	17
Dilico Ojibway Child and Family Services	Arnold Devlin	Sept. 20, 2005	27
Douglas Hospital	Mimi Israël, Psychiatrist-in-Chief; Co-director, Clinical Activities Directorate; Associate Professor, Department of Psychiatry, McGill University	May 6, 2005	14

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Douglas Research Hospital	Dr. Ashok Malla, Head of Research	Feb. 16, 2005	6
Empowerment Council	Jennifer Chambers, Coordinator	Feb. 15, 2005	5
	Randy Pritchard	Feb. 16, 2005	6
Families for Early Autism Treatment	Dr. Sabrina Freeman, Executive Director	June 7, 2005	19
Family Advisory Committee of Vancouver Mental Health Services	Joan Nazif, Chair	June 6, 2005	18
Farm Stress Line Advisory Group	Ken Imhoff, Manager	June 2, 2005	17
	Lil Sabiston, Chair		
First Nations of Quebec and Labrador Health and Social Services Commission	Jules Picard, Social Services Coordinator	June 21, 2005	23
	Isabelle Wood, Social Crises Issues Technical Coordinator		
Fitzroy Centre Programme	Tom MacLeod	June 16, 2005	22
From the Heart – Three Voices	Patricia Commins, Retired Teacher	Feb. 15, 2005	5
	Michael Flaxman, Volunteer		
	Douglas Millstone, Family Law Lawyer		
Halifax Regional Police	Christopher McNeil, Deputy Chief	May 10, 2005	15
Health and Community Services	Kim Baldwin, Director of Mental health and Addictions	June 14, 2005	22
Health and Social Services, Province of Prince Edward Island	Dr. Tina Pranger, Mental Health Consultant	June 16, 2005	22
Health Canada	Ian Potter, Assistant Deputy Minister, First Nations and Inuit Health Branch	April 20, 2005	13
	Kathryn Langlois, Director General, Community Programs Directorate, First Nations and Inuit Branch		

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Health Care Corporation of St. John's Region	Ian Shortall, Division Manager, Bridges Program	June 14, 2005	22
Home-Based Spiritual Care	Sister Lena Mangalam	June 21, 2005	23
Hong Food Mental Health Association	Raymond Chung, Head of Survivor Group	Feb. 17, 2005	7
Institute of Gender and Health	Madeline Boscoe	June 1, 2005	16
Institute of Health Promotion Research, University of British Columbia	Marc Corbière, Assistant Professor	July 5, 2005	25
Institutes of Neurosciences, Mental Health and Addiction, Douglas Research Centre	Dr. Rémi Quirion, Scientific Director	June 21, 2005)	23
Inuit Tapiriit Kanatami, Health Department	Larry Gordon, Chairman, National Inuit Committee on Health	April 21, 2005	13
Inuit Tapiriit Kanatami	Onalee Randell, Director of Health	Sept. 20, 2005	27
IWK Health Centre	Andy Cox, Consumer and Mental Health Advocate	May 6, 2005 May 10, 2006	14 15
	Wade Junek, Consulting Psychiatrist, Day Treatment Services	May 10, 2005	15
	Susan Mercer, Director, Mental Health Services		
	Herb Orlik, Clinical Director, Chief of Psychiatry		
Jean Tweed Centre	Nancy Bradley, Executive Director	Sept. 21, 2005	28
Laurel Centre	Deborah Palmer, Clinical Director	June 1, 2005	16
Manitoba Centre for Health Policy	Randall Fransoo, Researcher	June 1, 2005	16
McGill University	Dr. Norman Hoffman, Director, Student Mental Health Service	June 21, 2005	23

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
McMaster University, Department of Psychiatry and Behavioural Neurosciences	Dr. Ellen Lipman, Child Psychiatrist; Associate Professor, Division of Child Psychiatry; Core Member of Offord Centre for Child Studies	May 6, 2005	14
Mental Health and Addictions Advisory Committee, Five Hill Regional Health	Darrell Downton, Co-Chair	June 2, 2005	17
	Les Gray, Co-Chair		
	Ursan, Anne-Marie, Manager, Rehabilitation Services		
Mental Health and Organizational Development	Elizabeth Smailes, Director	July 5, 2005	25
Mental Health Association of Ontario	Mary-Ann Baynton, Director	July 5, 2005	25
Mental Health Evaluation and Community Consultation Unit, Department of Psychiatry, University of British Columbia	Merv Gilbert, Psychologist	July 5, 2005	25
Mental Health Services for Children, Youth and Families	Margaret Synyshyn, Program Director	June 1, 2005	16
Mental Health Services, South Shore DHA	Doug Crossman, Manager	May 9, 2005	15
Montreal Police Service	Michael Arruda, Agent and Counsellor, Action Strategies with the Community, Mental Health and Intellectual Disabilities	Feb. 16, 2005	6
Mood Disorders Association of British Columbia	Rennie Hoffman, Executive Director	June 7, 2005	19
Moose Jaw Police Service	Terry Coleman, Chief of Police Service and Co-Chair of the Canadian National Committee for Police/Mental Health Liaison	Feb. 16, 2005	6
National Aboriginal Health Organization	Bernice Downey, Executive Director	April 21, 2005	13
	Donna Lyon, Director	Sept. 20, 2005	27

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
National Defence	Brigadier-General Hilary F Jaeger, Surgeon General	Feb. 23, 2005	8
	Colonel D.R. Boddam		
National Indian & Inuit Community Health Representatives Organization	Debbie Dedam-Montour, Executive Director	Sept. 20, 2005	27
National Network for Mental Health	Constance McKnight, National Executive Director	May 11, 2005	15
Native Mental Health Association	Bill Mussell, Chair	Sept. 20, 2005	27
Native Psychologists of Canada	Dr. Arthur W. Blue, Psychologist	Sept. 20, 2005	27
New Brunswick Department of Health and Wellness	The Honourable Elvy Robichaud, Minister	May 11, 2005	15
	France Daigle, Provincial Coordinator, Suicide Prevention Program		
	Ken Ross, Assistant Deputy Minister		
Newfoundland and Labrador Early Psychosis Program	Dr. Kellie LeDrew, Clinical Director	June 15, 2005	22
Nodin Counselling	James Morris, Executive Director	Sept. 20, 2005	27
North Peace Tribal Council	Lorraine Boucher, Director of Health Programs	Sept. 20, 2005	27
Nunavut Kamatsiaqtut Help Line	Sheila Levy, President	Sept. 20, 2005	27
Office of Child and Family Services Advocacy of Ontario	Judy Finlay, Chief Advocate	May 6, 2005	14
Office of the Correctional Investigator of Canada	Nathalie Neault, Director of Investigations	June 7, 2005	19
	Howard Sapers, Correctional Investigator of Canada		
Office of the Ombudsman of Nova Scotia	Dwight Bishop, Ombudsman	May10, 2005	15
	Christine Brennan, Supervisor of Youth and Senior Services		

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Older Persons, Mental Health and Addictions Network of Ontario	Suzanne Crawford, Program Manager	June 8, 2005	20
Ontario Council of Alternative Businesses	Becky McFarlane, Partnership Coordinator	Feb. 15, 2005	5
Ontario Federation of Community Mental Health and Addiction	David Kelly, Executive Director	Sept. 21, 2005	28
Ontario Hospital Association	Dr. Paul Garfinkel, Chair, Working Committee on Mental Health	Feb. 17, 2005	7
Ontario Ministry of Health and Long-Term Care	Carrie Hayward, Acting Director, Mental Health and Addiction Branch, Community Health Division	Feb. 15, 2005	5
	Douglas Dixon, Senior Program Analyst		
Options Outreach Employment Inc.	Karen MacFarlane, Manager/Employment Counsellor	May 11, 2005	15
Our Voice/Notre Voix	Eugène Leblanc, Publisher and Editor	May 11, 2005	15
Partnership for Consumer Empowerment	Jason Turcotte, Canadian Mental Health Association office in Portage la Prairie	May 31, 2005	16
Pauktuutit Inuit Women's Association	Jennifer Dickson, Executive Director	Sept. 20, 2005	27
	Leesie Nagitarvik		
Providence Health Care	Dr. Elizabeth Drance, Geriatric Psychiatrist, Physician Program, Director for Residential Care Program Simon Fraser University	June 8, 2005	20
	Dr. Allan Burgmann, Clinical Assistant Professor, Psychiatry, University of Columbia		

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Providence Health Care	Dr. Kristin Sivertz, Physician Director, Mental Health Program and Head of the Department of Psychiatry	June 8, 2005	20
Provincial Suicide Prevention Committee	Patricia Doyle, Co-Chair	June 16, 2005	22
Psychiatric Association of Newfoundland and Labrador	Ted S.Callanan, President	June 15, 2005	22
Psychiatric Patient Advocate Services	Brenda McPherson, Provincial Coordinator	May 11, 2005	15
Queen's University, Division of Child and Adolescent Psychiatry	Dr. Nasreen Roberts, Director, Adolescent Inpatient and Emergency Service	May 6, 2005	14
Regional Mental Health Program	Dr. Alan Gordon	June 9, 2005	21
Registered Psychiatric Nurses of Canada	Robert Allen, Executive Director	June 2, 2005	17
Responsible Gaming Council Toronto	Dr. Jon Kelly, Chief Executive Officer	Sept. 21, 2005	28
Roots of Empathy	Mary Gaultois-Bungay, Trainer and Mentor	June 15, 2006	22
Royal Canadian Mounted Police	Staff Sergeant Michel Pelletier, Director, Drug Awareness Service	Sept. 21, 2005	28
Royal Newfoundland Constabulary	Sean Ryan, Inspector	Feb. 16, 2005	6
Sal'T'shan Institute	Bill Mussell, Manager and Principal Educator; Chair of the Native Mental Health Association	May 6, 2005	14
Saskatchewan Families for Effective Autism Treatment	Lisa Simmermon, Public Relations Director	June 2, 2005	17
Saskatchewan Psychiatric Association	Dr. David Keegan, Member	June 2, 2005	17
	Dr. Dhanpal Natarajan, Past Chair		
	Dr. Annu Thakur, Member		
Schizophrenia Digest	William J MacPhee, Founder and Publisher	June 7, 2005	19

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Schizophrenia Society of Canada	Florence Budden, President Elect	Feb. 17, 2005	7
Schizophrenia Society of Saskatchewan	Thomas Bartram, Member	June 2, 2005	17
	Carol Solberg, Executive Director		
School of Nursing, York University	Dr. Cheryl Van Daalen	May 6, 2005	14
Shepody Healing Centre	Bernard Galarneau, Psychologist, Political Director	May 11, 2005	15
Simon Fraser University	Charmaine Spencer, Gerontology Research Centre and Department of Gerontology	June 8, 2005	20
Social Development Canada	Cecilia Muir, Director General, Office of Disability Issues	April 21, 2005	13
	Georges Grujic, Director, Office of Disability Issues		
Social Services Centre of Sept-Iles	Dr. Manon Charbonneau, Psychiatrist	June 21, 2005	23
Stella Burry Community Services	Jocelyn Greene, Executive Director	June 15, 2005	22
Survivors of Suicide Support Group	George Tomie, Facilitator of the SOS Support Group and family member of a mental health consumer	May 9, 2005	15
Technical Advisory Committee on Tax Measures for Persons with Disabilities	Lembi Buchanan, President, Communications Resources and Member	July 5, 2005	25
The Canadian Psychiatric Research Foundation	Judy Hills, Executive Director	May 6, 2005	14
The College of Family Physicians	Dr. Louise Nasmith, President Elect and Chair of the Board of Directors	June 21, 2005	23
The Dream Team	Linda Chamberlain, Member	Feb. 15, 2005	5
	Phillip Dufresne, Member and Shapiro, Mark, Member		
The Empowerment Connection	Jean-Pierre Galipeault, Owner	May 9, 2005	15

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
The Gerstein Centre	Dr. Reva Gerstein, Founding, Chair	Feb. 15, 2005	5
	Paul Quinn, Director		
The Mental Health Programs of the Brandon Regional Health Authority	Albert Hajes, Regional Coordinator, Mental Health Programs	June 1, 2005	16
	Elaine Morris, Project Mental Health Worker, Children's Medication Follow-up Project, Brandon Mental Health Programs and Brandon School Division		
	Brent White, Program Manager, Residential and Support Services		
The Self Help Connection	Dr. Linda Bayers, Executive Director	May 10, 2005	15
Treasury Board Secretariat	Phil Charko, Assistant Secretary, Pension and Benefits Division	Feb. 23, 2005	8
Université du Québec à Montréal	Angelo Dos Santos Soares, Professor	July 5, 2005	25
Université du Québec en Outaouais	Romaine Malenfant, Professor-Researcher	July 5, 2005	25
University Health Network	Dr. Sidney H. Kennedy, Psychiatrist-in-Chief	June 21, 2005	23
Vancouver Coastal Health Association	Robena Sirett, Manager, Older Persons Adult Mental Health Services	June 8, 2005	20
Vancouver General Hospital	Dr. Martha Donnelly, Head, Division of Community Geriatrics	June 8, 2005	20
Vancouver Island Health Authority	Dr. R.E.W. Miller, Chief of Psychiatry, Medical Program Director	June 7, 2005	19
Vancouver Island Health Authority	Ken Moselle, Manager, Performance Standards and Monitorin Mental Health and Addiction Services	June 8, 2005	20

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Vancouver Richmond Mental Health Network	Lara Paul, Member	June 6, 2005	18
	Ron Carten, Coordinator		
	Susan Friday, President		
Veterans Affairs Canada	Brian Ferguson, Assistant Deputy Minister, Veteran Services Branch	Feb. 23, 2005	8
Victoria Order of Nurses (VON)	Judith Shamian, President and CEO	May 11, 2005	15
	Gordon Milak, VON, Middlesex-Elgin	Feb. 17, 2005	5
Waterford Hospital	Geralyn Dalton, Nurse Practitioner, Short Stay Unit	June 14, 2005	22
Well Connected	Heather Dowling	May 31, 2005	16
	Ruth Minaker		
West Prince Health Region	Jim Campbell, Mental Health Addictions Coordinator	June 16, 2005	22
Worker's Compensation Board of British Columbia	Peter Bogyo, Director of Corporate Planning	April 20, 2005	13

**APPENDIX C:
LIST OF WITNESSES⁴²⁸
-THIRD SESSION OF THE 37TH PARLIAMENT
(FEBRUARY 2, 2004 — MAY 23, 2004)**

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Alberta Mental Health Board	Ray Block, Chief Executive Officer	April 28, 2004	7
	Sandra Harrison, Executive Director, Planning, Advocacy & Liaison		
Anxiety Disorders Association of Canada	Peter McLean, Vice-President	May 12, 2004	9
As individuals	Charles Bosdet	April 29, 2004	7
	Pat Caponi		
	Don Chapman		
Australia, Government of <i>(by videoconference)</i>	Dermot Casey, Assistant Secretary, Health Priorities and Suicide Prevention Branch, Department of Health and Ageing	April 20, 2004	6
	Jenny Hefford, Assistant Secretary, Drug Strategy Branch, Department of Health and Ageing		
British Columbia Ministry of Health Services	Irene Clarkson, Executive Director, Mental Health and Addictions	April 28, 2004	7
Canadian Association of Social Workers	Stephen Arbuckle, Member, Health Interest Group	March 31, 2004	5
Canadian Medical Association	Dr. Sunil Patel, President	March 31, 2004	5
	Dr. Gail Beck, Acting Associate Secretary General		

⁴²⁸ The Committee proceedings from the Third Session of the 37th Parliament are available at :
http://www.parl.gc.ca/common/Committee_SenProceed.asp?Language=E&parl=37&Ses=3&comm_id=47

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Canadian Mental Health Association	Penny Marrett, Chief Executive Officer	May 12, 2004	9
Canadian Nurses Association, the Canadian Federation of Mental Health Nurses and the Registered Psychiatric Nurses of Canada	Nancy Panagabko, President, Canadian Federation of Mental Health Nurses	March 31, 2004	5
	Annette Osted, Board Member, Registered Psychiatric Nurses of Canada		
Canadian Psychiatric Association	Dr. Blake Woodside, Chairman of the Board	March 31, 2004	5
Canadian Psychological Association	John Service, Executive Director	March 31, 2004	5
Centre for Addiction and Mental Health	Christine Bois, Provincial Priority Manager for Concurrent Disorders	May 5, 2004	8
	Wayne Skinner, Clinical Director, Concurrent Disorder Program		
	Brian Rush, Research Scientist, Social Prevention and Health Policy		
Centre for Suicide Prevention	Diane Yackel, Executive Director	April 21, 2004	6
Cognos	Marilyn Smith-Grant, Senior Human Resources Specialist	April 1, 2004	5
Correctional Service of Canada	Larry Motiuk, Director General, Research	April 29, 2004	7
	Françoise Bouchard, Director General, Health Services	April 29, 2004	7
Douglas Hospital	Dr. Gustavo Turecki, Director, McGill Group for Suicide Studies, McGill University	April 21, 2004	6

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
House of Commons	The Honourable Jacques Saada, P.C., M.P., Leader of the Government in the House of Commons and Minister responsible for Democratic Reforms	April 1, 2004	5
Human Resources and Skills Development Canada	Bill Cameron, Director General, National Secretariat on Homelessness	April 29, 2004	7
Human Resources and Skills Development Canada	Marie-Chantal Girard, Strategic Research Manager, National	April 29, 2004	7
Institute of Neurosciences, Mental Health and Addiction	Richard Brière, Assistant Director	April 21, 2004	6
McGill University <i>(by videoconference)</i>	Dr. Laurence Kirmayer, Director, Division of Social and Transcultural Psychiatry, Department of Psychiatry	May 13, 2004	9
Mood Disorder Society of Canada	Phil Upshall, President	May 12, 2004	9
Native Mental Health Association of Canada	Brenda M. Restoule, Psychologist and Ontario Board Representative	May 13, 2004	9
New Zealand, Government of <i>(by videoconference)</i>	Janice Wilson, Deputy Director General, Mental Health Directorate, Ministry of Health	May 5, 2004	8
	David Chaplow, Director and Chief Advisor of Mental Health		
	Arawhetu Peretini, Manager of Maori Mental Health		
	Phillipa Gaines, Manager of Systems Development of Mental Health		
Nova Scotia Department of Health	Dr. James Millar, Executive Director, Mental Health and Physician Services	April 28, 2004	7
Ontario Federation of Community Mental Health and Addiction	David Kelly, Executive Director	May 5, 2004	8

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Ontario Hospital Association	Dr. Paul Garfinkel, Chair, Mental Health Working Group	March 31, 2004	5
Privy Council Office	Ron Wall, Director, Parliamentary Operations, Legislation and House Planning	April 1, 2004	5
	Ginette Bougie, Director, Compensation and Classification		
Public Service Alliance of Canada	John Gordon, National Executive Vice-President	April 1, 2004	5
	James Infantino, Pensions and Disability Insurance Officer		
Schizophrenia Society of Canada	John Gray, President-Elect	May 12, 2004	9
Simon Fraser University <i>(by videoconference)</i>	Margaret Jackson, Director, Institute for Studies in Criminal Justice Policy	April 29, 2004	7
Six Nations Mental Health Services	Dr. Cornelia Wieman, Psychiatrist	May 13, 2004	9
Treasury Board Secretariat	Joan Arnold, Director, Pensions Legislation Development, Pensions Division	April 1, 2004	5
U.S. Campaign for Mental Health Reform	William Emmet, Coordinator	April 1, 2004	5
U.S. President's New Freedom Commission on Mental Health <i>(by videoconference)</i>	Michael Hogan, Chair	April 1, 2004	5
United Kingdom, Government of <i>(by videoconference)</i>	Anne Richardson, Head of the Mental Health Policy Branch, Department of Health	May 6, 2004	8
	Adrian Sieff, Head of the Mental Health Legislation Branch		

**APPENDIX D:
LIST OF WITNESSES⁴²⁹**

**-SECOND SESSION OF THE 37TH PARLIAMENT
(SEPTEMBER 30, 2002 — NOVEMBER 12, 2003)**

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Alzheimer Society of Canada	Steve Rudin, Executive Director	June 4, 2003	17
As individuals	Thomas Stephens, Consultant	March 20, 2003	11
	Nancy Hall, Mental Health Consultant	May 28, 2003	16
	J. Michael Grass, Past Chair, Champlain District Mental Health Implementation Task Force	June 5, 2003	17
	Loïse David Murray Ronald	Feb. 26, 2003	9
Canadian Academy of Psychiatric Epidemiology	Dr. Alain Lesage, Past President	March 19, 2003	11
Canadian Academy of Psychiatry and the Law	Dr. Dominique Bourget, President	June 5, 2003	17
Canadian Coalition for Senior Mental Health	Dr. David K. Conn, Co-Chair; President, Canadian Academy of Geriatric Psychiatry	June 4, 2003	17
Canadian Institute for Health Information	Dr. John S. Millar, Vice-President, Research and Analysis	March 20, 2003	11
	Carolyn Pullen, Consultant	March 20, 2003	11
	John Roch, Chief Privacy Officer and Manager, Privacy Secretariat	March 20, 2003	11
Canadian Institutes of Health Research	Bronwyn Shoush, Board Member, Institute of Aboriginal Peoples' Health	May 28, 2003	16

⁴²⁹ The Committee proceedings from the Second Session of the 37th Parliament are available at : http://www.parl.gc.ca/common/Committee_SenProceed.asp?Language=E&parl=37&Ses=2&comm_id=47

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Canadian Institutes of Health Research	Jean-Yves Savoie, President, Advisory Board, Institute of Population and Public Health	June 12, 2003	18
	Dr. Rémi Quirion, Scientific Director, Institute of Neurosciences, Mental Health and Addiction	May 6, 2003	14
Canadian Mental Health Association — Ontario Division	Patti Bregman, Director of Programs	June 12, 2003	18
Canadian Paediatric Society	Dr. Diane Sacks, President-Elect	May 1, 2003	13
	Marie-Adèle Davis, Executive Director	May 1, 2003	13
Centre for Addiction and Mental Health	Jennifer Chambers, Empowerment Council Coordinator	May 14, 2003	15
	Rena Scheffer, Director, Public Education and Information Services	May 28, 2003	16
Centre hospitalier Mère-enfant Sainte-Justine	Dr. Joanne Renaud, Child and Adolescent Psychiatrist; Young Investigator, Canadian Institutes of Health Research	April 30, 2003	13
Children's Hospital of Eastern Ontario	Dr. Simon Davidson, Chairman, Division of Child and Adolescent Psychiatry	May 1, 2003	13
CN Centre for Occupational Health and Safety	Kevin Kelloway, Director	June 12, 2003	18
Douglas Hospital	Eric Latimer, Health Economist	May 6, 2003	14
	Dr. James Farquhar, Psychiatrist		
	Dr. Mimi Israël, Head, Department of Psychiatry; Associate Professor, McGill University		
	Myra Piat, Researcher		
	Ampara Garcia, Clinical Administrative Chief, Adult Ultraspecialized Services Division		

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Douglas Hospital	Manon Desjardins, Clinical Administration Chief, Adult Sectorized Services Division	May 6, 2003	14
	Jacques Hendlisz, Director General		
	Robyne Kershaw-Bellmare, Director of Nursing Services		
Global Business and Economic, Roundtable and Addiction and Mental Health	Rod Phillips, President and Chief Executive Officer, Warren Shepell Consultants	June 12, 2003	18
Hamilton Health Sciences Centre	Venera Bruto, Psychologist	June 4, 2003	17
Health Canada	Tom Lips, Senior Advisor, mental Health, Healthy Communities Division, Population and Public Health Branch	March 19, 2003	11
	Pam Assad, Associate Director, Division of Childhood and Adolescence, Centre for Healthy Human Development, Population and Public Health Branch	April 30, 2003	13
Laval University	Dr. Michel Maziade, Head, Department of Psychiatry, Faculty of Medicine	May 6, 2003	14
Louis-H. Lafontaine Hospital	Jean-Jacques Leclerc, Director, Rehabilitation Services and Community Living	May 6, 2003	14
	Dr. Pierre Lalonde, Director, Clinique jeunes adultes	May 6, 2003	14
McGill University	Dr. Howard Steiger, Professor, Psychiatry Department; Director, Eating Disorders Program, Douglas Hospital	May 1, 2003	13

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
Province of British Columbia	Patrick Storey, Chair, Minister's Advisory Council on Mental Health	May 14, 2003	15
	Heather Stuart, Associate Professor, Community Health and Epidemiology		
Queen's University	Dr. Julio Arboleda-Florèz, Professor and head, Department of Psychiatry	March 20, 2003	11
Registered Psychiatric Nurses of Canada	Margaret Synyshyn, President	May 29, 2003	16
Statistics Canada	Lorna Bailie, Assistant Director, Health Statistics Division	March 20, 2003	11
St. Joseph's Health Care London	Maggie Gibson, Psychologist	June 4, 2003	17
St. Michaels Hospital	Dr. Paul Links, Arthur Sommer Rothenberg Chair in Suicide Studies	March 19, 2003	11
Université du Québec à Montréal	Henri Dorvil, Professor, School of Social Work	May 6, 2003	14
	Dr. Michel Tousignant, Professor, Centre de recherche et intervention sur le suicide et l'euthanasie	May 6, 2003	14
University of British Columbia	Dr. Charlotte Waddell, Assistant Professor, Mental Health Evaluation and Community Consultation Unit, Department of Psychiatry, Faculty of Medicine	May 1, 2003	13
University of Calgary	Dr. Donald Addington, Professor and Head, Department of Psychiatry	May 29, 2003	16
University of Manitoba	John Arnett, Head, Department of Clinical Health Psychology, Faculty of Medicine	May 28, 2003	16
	Robert McIlwraith, Professor and Director, Rural and Northern Psychology Program	May 29, 2003	16

ORGANIZATION	NAME, TITLE	DATE OF APPEARANCE	ISSUE NO.
University of Montreal	Laurent Mottron, Researcher, Department of Psychiatry, Faculty of Medicine	May 6, 2003	14
	Dr. Richard Tremblay, Canada Research Chair in Child Development, Professor of Pediatrics, Psychiatry and Psychology, Director, Centre of Excellence for Early Childhood Development		
	Dr. Jean Wilkins, Professor and Paediatrics, Faculty of Medicine		
	Dr. Renée Roy, Assistant Clinical Professor, Department of Psychiatry, Faculty of Medicine		
University of Ottawa	Tim D. Aubry, Associate Professor; Co-Director, Centre for Research and Community Services	June 5, 2003	17
	Dr. Jeffrey Turnbull, Chairman, Department of Medicine, Faculty of Medicine		
University of Toronto	Dr. Joe Beitchman, Professor and Head, Division of Child Psychiatry, Department of Psychiatry; Psychiatrist-in-Chief, Hospital for Sick Children	April 30, 2003	13
	Dr. David Marsh, Clinical Director, Addiction Medicine, Centre for Addiction and Mental Health	May 29, 2003	16