



SPEAKING NOTES FOR

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TO

BOARD OF DIRECTORS,

CANADIAN ASSOCIATION OF CHIEFS OF POLICE

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Introduction

Thank you Commissioner Fantino for your kind introduction.

I want to thank the CACP's Board of Directors and Executive for providing me with this opportunity to update you on the work of the Mental Health Commission of Canada and, more specifically, the Commission's work in the area of mental health and the law.

By working together on many initiatives, the Commission and the CACP are already making great progress. Today, I will also update you on those initiatives, and share with you my thoughts on what more we could be doing jointly.

Joining me today is Dr. Dorothy Cotton. Dorothy is a psychologist with Correctional Service Canada's Ontario Region. She, along with former Moose Jaw Police Chief, Terry Coleman, are leading the CACP's Police/Mental Health Liaison projects. And, last but not least, Dorothy and Terry both sit on the Mental Health Commission's Advisory Committee on Mental Health and the Law. Together, they oversee the joint initiatives between the CACP and the Commission. I thank both Dorothy and Terry for their great contribution in advancing the Commission's agenda.

Background

Our Commission grew out of the most extensive consultation on mental health ever conducted in this country. That consultation formed the basis of a report published in May 2006 by a Senate Committee chaired by former Senator Michael Kirby.

The Committee's report, called *Out of the Shadows At Last*, looked at mental illness from the perspective of both the mental health system and the total health care system in Canada. One of its key recommendations was the creation of a national organization to address mental health issues. Less than a year later, the federal government provided funding for the Mental Health Commission of Canada. The Commission held its first board meeting in September 2007.

The Commission is a non-profit organization, but we are not a service provider. We are a catalyst and our mandate is to focus national attention on mental health. The Commission is funded by the federal government, but operates at arm's length from the government. It has the support of all provincial and territorial governments except Quebec.

The challenge we are addressing is enormous.

This year, seven million Canadians will experience a mental illness. Just imagine – that is one person in five; and that person could be a colleague at work, a neighbour or a family member.

It's sad to say, but many of these people will not get help because either they can't access services or, worse yet, they're too ashamed or afraid to come forward because of the stigma associated with mental illness.

People living with mental illness have the right to obtain the services and supports they need. They have the right to be treated with the same dignity and respect as we accord everyone struggling to recover from any form of illness.

The Commission has been tasked with undertaking four key initiatives:

- creating a mental health strategy for Canada – we're the only G8 country without one!

- conducting ‘Mental Health and Homelessness’ research demonstration projects;
- developing a 10-year anti-stigma / anti-discrimination initiative; and
- establishing a Knowledge Exchange Centre.

From a standing start in 2007, we’ve created an organization and hired staff.

We’ve also established advisory committees to address eight key areas – Child and Youth; Mental Health and the Law; Seniors; First Nations, First Nations Inuit and Métis; Workforce; Family Caregivers; Service Systems; and Science. With representatives from across the country, these Committees guide research in their areas of expertise, and provide both advice to the Commission’s Board, and support to our key initiatives.

National mental-health strategy

The Commission is developing a comprehensive framework for a national mental-health strategy focused on the dual notions of “hope” and “recovery”.

Contrary to a popular misconception surrounding mental illness, recovery is possible for the vast majority of people who live with mental illness. They can become fully functioning citizens and family members. They can lead full and rich lives within the limitations imposed by their illness, just as people live with asthma, diabetes or epilepsy. We want to offer Canadians with mental illness real hope and real solutions.

The Commission recently completed a draft vision for what a transformed mental-health system in Canada should look like. We conducted extensive public consultations on this vision – visiting 13 cities across Canada and meeting with a wide cross-section of stakeholders. More than 1,700 Canadians also participated in an online consultation. The framework looks across the spectrum of mental-health programs, supports and policy, recognizing the reality of Canadian federalism. The framework is sensitive to the fact that the delivery of publicly funded health care is a provincial / territorial responsibility and any national strategy must be tailored to that reality.

Homelessness

Another major area of concern to the Commission is the large population of homeless people with mental illnesses.

Homelessness across Canada is growing at an alarming rate, and about half of all people who are homeless also have a mental illness. People with mental illnesses must have both a safe place to live and some continuity in their lives in order to effectively access health services and mental health treatments.

The Commission is now conducting the largest research project of its kind in the world –studying mental health and homelessness.

In its February 2008 budget, the federal government committed \$110 million to the Commission to undertake a series of research projects over a five-year period to determine how to most effectively help the homeless mentally ill, including improving access to primary health care and to housing.

We’re currently setting up demonstration sites in five cities across Canada – Vancouver, Winnipeg, Toronto, Montreal and Moncton.

In each city, we're focusing on a distinct group of homeless people living with mental illness. For example, in Winnipeg the target group is urban Aboriginals; and in Vancouver, we're focusing on people who struggle with substance abuse and addictions.

We're using the 'housing first' model as a foundation for this initiative. As a result, 1,325 of the 2,225 homeless mentally ill people who will participate in the study will receive housing and support services. The remainder will receive the regular services that are available in the test cities.

Collectively, the projects will develop a body of evidence that will enable Canada to lead the world in providing services to homeless people living with mental illness.

Anti-stigma / Anti-discrimination Initiative

Another major initiative of the Commission is our 10-year anti-stigma / Anti-discrimination campaign.

This will be the largest systematic effort to reduce the stigma of mental illness in Canadian history.

It is one of our toughest jobs.

Stigma and discrimination exact a huge personal toll on people with mental health problems.

During the Senate Committee consultation, people living with mental illness said that the stigma and discrimination they face from the people closest to them – particularly family, friends and co-workers – often hurts them more than the disease itself.

It is very difficult to change people's attitudes and behaviours. Stigma, including self-stigma, is seen as one of the major hurdles preventing people with mental health problems from seeking treatment, maintaining employment and leading full and productive lives.

Our anti-stigma campaign is taking a multi-pronged approach that includes education, direct contact with people living with mental illness, and challenges to discriminatory policies and practices in organizations and governments.

The Commission is targeting two groups in the first phase of the plan:

1. children and youth – because 70% of mental illnesses in adults have their onset during adolescence or childhood; and
2. health care professionals – because people with mental illness tell us they experience stigma and discrimination from service providers in the healthcare system.

We know full well that it will take some time for the Commission to change Canadians' perceptions about mental illness because in many cases we're up against entrenched attitudes, behaviours, fears, prejudices, preconceptions and misconceptions.

However, we also know from the experiences of Australia, New Zealand and elsewhere that a sustained, multi-year anti-stigma campaign can change public attitudes. So we are confident that we will ultimately succeed.

Mental Health and the Law Advisory Committee

Earlier I mentioned that the Commission has eight advisory committees. They are working on about 24 projects, all of which are integral to the Commission's key initiatives.

Our advisory committee on Mental Health and the Law is chaired by His Honour, Justice Edward Ormston, who was appointed to the Ontario Court of Justice in 1989. Ted was instrumental in creating, in Ontario, the world's first Mental Health Court. He is currently seconded as Chair of the Mental Health Consent and Capacity Board. He also lectures extensively on mental health issues to judges across Canada and internationally.

Twelve committee members work with Justice Ormston, including Dorothy Cotton and Terry Coleman.

The Committee is interested in the points at which people with mental illness intersect with the law. That means looking at both how laws impact people with mental illnesses and the experiences of people with mental illness when they encounter the criminal justice system.

Specifically:

- The Committee is developing tools to assess how the law currently impacts the human rights of people with mental health problems.
- They're examining the evolution of procedures and best practices in mental health care for correctional facilities.
- They're determining whether changes to the current criminal justice system could help reduce the number of mentally ill people within it; and whether changes to the system could provide mentally ill people with improved access to hospital care before their actions lead them to enter the criminal justice system.
- And they're examining best practices in the interactions of police services with people who have a mental illness;

For example, the Commission is now funding a major study to analyse and assess the interactions that people living with mental health problems and illnesses have with the police. The Commission is funding the study for \$100,000 and Dorothy Cotton and Terry Coleman are overseeing it.

There is a common public perception that police only deal with people with mental health issues in times of crisis and that those interactions are largely negative. The news media tends to focus on the very rare and extremely unfortunate occurrences that end badly.

However, we know that of the estimated three million interactions police have each year with people living with mental illness, the vast majority are *not* in crisis situations and only a small minority result in apprehensions under the various Mental Health Acts.

In fact, most of these three million contacts are informal and supportive – everything from a police officer reassuring a person with delusions or assisting neighbours who are concerned with the welfare of an apparently unwell person next door.

I was struck by a letter to the editor in *The Globe and Mail* last month from a relative of a mental health patient. The correspondent wrote “we have found that the most supportive and humane approaches tend to be from police and social workers at the ‘first contact’ street level”.¹

These sorts of interactions don't get documented at all and, to date, there has been *no* research that has specifically examined the attitudes of persons with mental illness toward the police.

¹ Letter to the Editor from Peter R. Saunders of Aurora, Ontario. *The Globe and Mail*, Wednesday, 29 July 2009

So, that's what our new study is setting out to do. It will:

1. examine the perceptions of persons living with severe mental health problems and illness of their interactions with the police;
2. determine the attitudes of persons with mental illness toward police in general; and
3. solicit feedback that persons with mental illness would like to convey to police.

Ultimately, we hope that this information will contribute to the development of evidence-based best-practice guidelines for police training and education programs. The study will also inform the development and evolution of specialized police response services.

I am aware of the very significant work that the CACP has already done in the area of improving the level and quality of police interaction with people with mental illnesses. The CACP's Human Resources Committee has been doing commendable work for almost a decade now and I sincerely hope this new study will help you make further advances.

Future MHCC and CACP collaboration

We believe there are many areas for future collaboration that would be mutually beneficial to both the Commission and the CACP.

To name a few:

Firstly, we need to ensure Mental Health Act information no longer appears on police record checks.

Both the Commission and the CACP are already in full agreement – that police services simply should *never* report Mental Health Act apprehensions on police record checks. It is health information. By declining to pass on information that might be misleading and discriminatory, the rights of the person with the mental illness are protected.

In this way, individuals who have a history of Mental Health Act apprehensions would not be arbitrarily disqualified from employment opportunities or turned away when they try to cross the border because of a minor MHA incident that occurred 20 years ago.

Action is already being taken to eliminate this practice but there is still significant variability from one jurisdiction to another. The Commission believes the time is ripe to eliminate this practice across Canada once and for all. It would be most helpful to see the CACP take a national leadership role in this regard.

Secondly, regarding homelessness, we see an opportunity for Canadian police services to take a leadership role in assessing police practices towards people living on the street.

Thirdly, I talked earlier about the Commission's 10-year anti-stigma / anti-discrimination campaign. We believe there is an opportunity for the Commission and the CACP to collaborate on developing anti-stigma materials and campaigns specific to the police community.

And this could tie in with a **fourth area of endeavour** – that is, addressing the workplace mental health of police officers and police employees.

We are aware that while police services in general do a very good job in providing services around critical incidents and post-traumatic stress disorder, less attention has been focused to date on such things as anxiety and depression and the stigma and self-stigma that go hand-in-hand with those.

I understand a very good start has been made with the CACP's involvement last year in the 4th Annual Canada/U.S. Forum on Mental Health and Productivity, which was dedicated to issues related to policing and the military.

Mental illness strikes men and women in their prime working years. In fact, 20 to 25 percent of the labour force is affected by mental health issues – that's one out of every four to five employees! No other illness has such an impact.

The economic price tag of mental illness in the workplace is skyrocketing.

Mental illness and addiction are significant causes of disability in Canada, the United States and Western Europe. Of the 10 leading causes of disability worldwide, *five* are related, in one way or another, to mental disorders.

Mental health claims, especially for depression, have overtaken cardiovascular disease as the fastest growing category of disability costs in Canada.

In 2002, it was estimated that mental health and addiction cost Canada 33 billion dollars a year in lost output and redundant wage costs. But only five years later, in late 2007, mental disorders and addictions cost this much in Ontario alone.

In the workplace, we're seeing the full spectrum of mental health issues – from so-called 'burn-out' to depression to short-term disability – and then to long-term disability – all with limited intervention by the health-care system.

Disability from mental illness represents anywhere up to 12 per cent of payroll costs in Canada. These costs, both hidden and direct, can only escalate in the future if nothing is done about them now.

We believe it is in interest of all organizations to improve the mental health of their employees. Greater employee sustainability means greater organizational and business sustainability – a key consideration in these troubled times.

The Commission's Workforce advisory committee is developing a plan to ensure that key organizational personnel make mental health in their own workforces a priority.

The idea is to help all workforce leaders change the way mental health is dealt with so that workforce environments are more capable of dealing with mental health matters in a manner that leads to the betterment of the workforce and the workplace.

I look forward to the CACP's Human Resources Committee working with our Commission to advance this agenda across police services and, we hope, jointly embark on a project in the not-too-distant future in this regard.

Conclusion

I sincerely hope and believe that by building and expanding our collaborative efforts, the Commission and the CACP can make a significant, positive impact on Canadians as a whole and the police services that serve our communities nationwide.

Mental illness doesn't discriminate. It affects people of every age – every walk of life – rich and poor.

The Mental Health Commission is determined to fulfill its mandate so that all Canadians living with mental health problems and mental illness will have a better quality of life than ever before.

We look forward to continuing our work with the CACP to ensure that, together, we keep mental health out of the shadows forever.

Thank you for your interest and kind attention.