



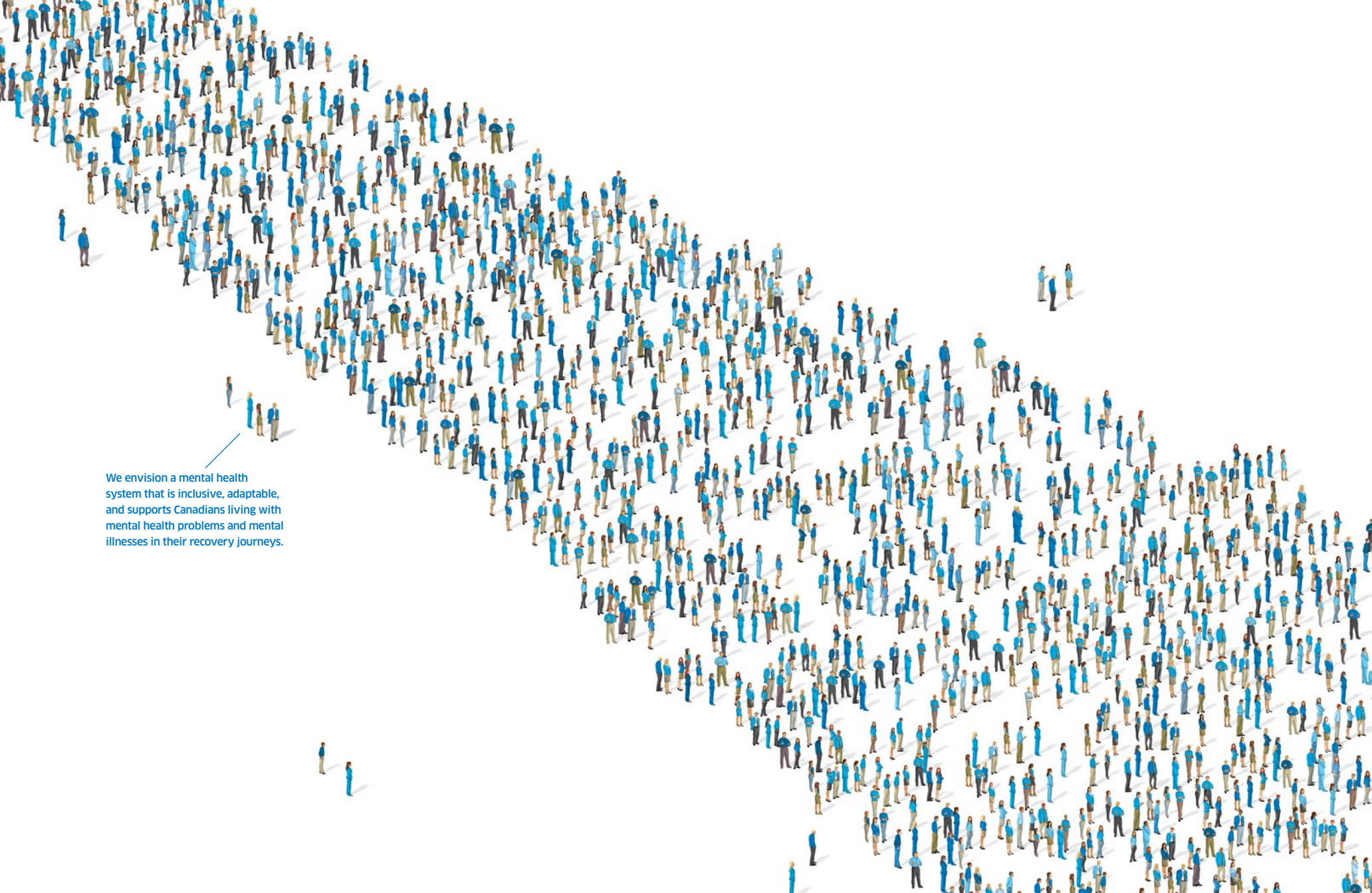
Together We Accelerate The Change: Taking Action on the Mental Health Strategy for Canada

ANNUAL REPORT 2013-14




Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada



We envision a mental health system that is inclusive, adaptable, and supports Canadians living with mental health problems and mental illnesses in their recovery journeys.



Guided by **Changing Directions, Changing Lives:**
The Mental Health Strategy for Canada, the Mental Health Commission of Canada is a catalyst for improving the mental health system and changing the attitudes and behaviours of Canadians around mental health issues. Through its unique mandate from Health Canada, the MHCC is Canada's coordinating agent, bringing together the best and most influential minds in the mental health community. The time has come for the MHCC to accelerate the pace of change for the benefit of all Canadians.

Together, we accelerate the change!



OUR VISION: A society that values and promotes mental health and helps people living with mental health problems and mental illnesses to lead meaningful and productive lives.

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

Now is the time to seize on the
momentum we have built together
and to accelerate the change!



Table of Contents

Message from the Chair, and President and CEO 4

Executive Summary: *The Mental Health Strategy for Canada* 9

The Recovery Initiative 12

Housing and Homelessness 16

Knowledge Exchange Centre 20

Mental Health First Aid (Canada) 24

Opening Minds 28

Workplace Mental Health 32

Final Words 39

Financial Statements 40

Leadership and Governance 48

Contact 49



Message from the Chair of the Board, David Goldbloom, and President and CEO, Louise Bradley

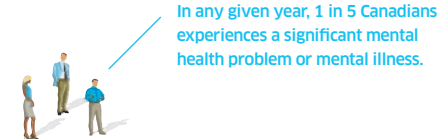
The Mental Health Commission of Canada continues to focus national efforts to accelerate bold and necessary change within our mental health system. Together with our many partners, we are leading a nationwide conversation – engaging policy makers at all levels of government, along with health professionals, volunteers, families, and people with lived experience of mental health problems and mental illnesses – to accelerate the change.

WE ENVISION a system that is inclusive, that is adaptable, and that supports the nearly seven million Canadians living with mental health problems and mental illnesses – and their families – in their recovery journey. Supporting recovery means ensuring people have access to a range of services and choices, such as medication, psychiatric services, counselling, peer support, and spiritual and cultural approaches.

Guided by *Changing Directions, Changing Lives: the Mental Health Strategy for Canada* – which is a blueprint for change across the system – we envision a country where all Canadians benefit from equitable access to appropriate and timely mental health services and supports. We draw our ongoing

priorities from the Strategy: helping Canadians break the stigma surrounding mental illness, housing Canadians with chronic mental illness, setting the standard for healthier workplaces, and creating real tools that promote mental health and prevent suicide.

In our efforts to get Canadians talking about mental illness, our Opening Minds program has gone from *creating knowledge* to *creating change*. Opening Minds links key audiences, including youth, health care providers, the workforce, and the media, with effective anti-stigma programs. We are committed to working with our partners across Canada to advance this national conversation.



The results of the MHCC's At Home/Chez Soi research project – using the Housing First approach – showed us a roadmap to a future where people living with serious mental illness no longer find themselves homeless. In a study that involved more than 2,000 Canadians who were chronically homeless with lived experience of mental illness, the results indicate that a Housing First approach can make a real difference in ending homelessness. At Home gave participants access to appropriate care and fostered engagement in their recovery. With the assistance and leadership of all levels of government, Canada now has the tremendous opportunity to implement Housing First across the country.



“I’m grateful to MHCC for providing us this opportunity to start a dialogue across Canada on suicide prevention. To quote my friend Scott Chisholm of the Collateral Damage Project, ‘We need to talk about suicide and suicide prevention, because NOT talking about it is NOT working.’”

– Dr. Harold Albrecht, Member of Parliament for Kitchener-Conestoga

We know it works in big and small cities and small towns, and can be tailored to meet the needs of diverse communities, including youth, First Nations, Inuit, and Métis, and new Canadians.

Launched in 2013, the *National Standard for Psychological Health and Safety in the Workplace* is inspiring employers to prioritize mental health and wellbeing with the same commitment that has been given to physical safety. To further quantify its impact, we have undertaken a Case Study Project which follows more than 40 organizations as they implement the Standard. The results will help Canadian employers stem the tide of billions of dollars in lost productivity.

Our efforts to improve workplace wellness extend to those individuals employed in police service organizations across the country. In the past year, we have worked closely with the Canadian Association of Chiefs of Police (CACP) to create a new national framework for police training and education that will be adopted by CACP and its membership. Our shared objective is to improve the outcome of interactions between police and individuals living with mental illnesses, while encouraging increased focus on the mental health of first responders and mentally healthy workplaces.

The MHCC is uniquely positioned to champion mental health issues – and to

support others who wish to take up the call. That is why we have invited Canada’s 308 federally elected Members of Parliament to engage their constituents in a frank and open conversation about suicide prevention. We have given them the tools they need to lead these local dialogues, and we plan to use the results of these community meetings to inform the development of a best practice community model for suicide prevention.

The MHCC continues to share knowledge and resources to advance best practices in mental health care in Canada. Our Knowledge Exchange Centre has brought together local and international practitioners to discuss significant issues



in mental health care, utilizing technology in new ways to keep people informed and connected. Mental Health First Aid Canada's network of trainers educated more than 100,000 Canadians about how to assist someone experiencing a mental health crisis to get the help they need. With over 1,000 trainers across Canada, Mental Health First Aid has the potential to help countless others in communities across the country.

As we strive to bring about change, *The Mental Health Strategy for Canada* is our blueprint. Together with our partners, we are making tremendous progress. Now is the time to accelerate the momentum we have built, and to make even greater strides.

Going forward, the MHCC will continue to inform, catalyze, and collaborate in the pursuit of progress that is so desperately needed for Canadians living with mental health problems and mental illnesses and their families.

Please read more about our work to date and future plans in the pages ahead.

Join us – and accelerate the change!

Sincerely,

Louise Bradley, MS, RN, CHE **David Goldbloom, OC, MD, FRCPC**

President and CEO

Board Chair

THE MENTAL HEALTH COMMISSION OF CANADA

“

A key next step will be the development of a detailed implementation plan for the [Mental Health] strategy. This plan should continue to build partnerships with the many key stakeholders involved in the strategy's creation.

All departments of government and all levels of government need to take a 'whole of government' approach and adequately fund the strategy's implementation. Without this commitment, Canada's first-ever national mental health strategy blueprint will join the many other reports and recommendations that are not implemented and will result in no real improvements in mental health and mental illness services for Canadians.

The Federal government has the opportunity to lead by example by improving its capacity to develop mental health policy and deliver services in areas for which it has direct responsibility such as First Nations, Inuit and Métis, National Defence, Veterans Affairs and Corrections.”

– David Copus, National Board Chair, CMHA



Executive Summary

The Mental Health Strategy for Canada: Accelerating the Pace of Change



The Strategy is a blueprint to create lasting change for Canadians.

THE MENTAL HEALTH COMMISSION OF CANADA (MHCC) has, as central to its mandate, two objectives:

- > CREATE a national mental health strategy
- > ENABLE that strategy for the explicit purpose of improving Canada's mental health system

In May 2012, the MHCC gave Canadians a blueprint for lasting change, when it released *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* – the nation's first national mental health strategy. In the time since, the Commission has continued its work with partners and stakeholders across Canada

to address the strategic directions outlined in the Strategy and encourage lasting implementation of the document's more than 100 recommendations.

By driving much-needed research and initiatives on housing and homelessness, the workplace, stigma, mental health and the law, Mental Health First Aid (Canada), recovery, and suicide prevention, the MHCC is transforming policy and practice with an aim to improving the mental wellbeing of Canadians.

As a national leader on mental health, the MHCC has continued to bring key partners to the table, including corporations,

governments, professional associations and unions, community organizations and mental health agencies across Canada. As well, it has further solidified its role as a trusted adviser on mental health, staying apprised and ahead on matters of innovation, leading practices, tools, and resources.

Executing this work has validated the need for continued leadership from the MHCC as a pan-Canadian coordinating agent – enabling the blueprint provided by the *Mental Health Strategy for Canada* and putting plans into action to create lasting change for Canadians.



Marking achievements made one year after the launch of the *National Standard for Canada for Psychological Health and Safety in the Workplace* (l-r) David Goldbloom, MD, Chair, MHCC; Ken Georgetti, President, Canadian Labour Congress; Hon. K. Kellie Leitch, MD, Minister of Labour and Minister of Status of Women; Louise Bradley, President and CEO, MHCC; Valerie Pringle, emcee; and George Cope, President and CEO, BCE and Bell Canada.



1



2

1. On June 10, 2013, MHCC President and CEO Louise Bradley and former MHCC Advisory Council Member Patrick Baillie were called to testify before the House of Commons Standing Committee on Justice regarding Bill C-54, An Act to amend the Criminal Code provisions dealing with those deemed not criminally responsible on account of a mental disorder.

2. Don Mahleka, Operations Manager of the Ngen Youth Centre, shares his story at the MHCC's Aspiring Workforce Report launch in Ottawa on October 9, 2013.

3. Mental Health First Aid (Canada) reaches all parts of the nation, including the North. In Labrador, these MHFA students (l-r) Jenny Bennett, Rosina Holwell, and Cornelia Tuglavina – select painting supplies they'll use to depict their experience with mental health problems and illness.



3



4

(inset) "Spring Hunt" painted by Harry Semigak, a participant in a community consultation and art-making workshop for Mental Health First Aid for Inuit, Nain, Labrador in May, 2014.

4. The 2013 Supporting the Promotion of Activated Research and Knowledge (SPARK) Training Workshop, July 10-11 in Victoria, BC, brought together participants from across Canada for training with internationally respected knowledge exchange professionals.





The Recovery Initiative: Making Recovery a Reality in Practice, as well as Policy

Recovery is a process in which people living with mental health problems and mental illnesses are actively engaged in their own journey of wellbeing. It is not a new idea. It has been developed and championed by people with lived experience of mental health problems and mental illnesses for decades.

THE MENTAL HEALTH STRATEGY FOR CANADA has as its Strategic Direction 2: **Foster wellbeing for people of all ages living with mental health problems and mental illnesses, and uphold their rights.**

Recovery journeys build on individual, family, cultural, and community strengths and can be supported by many types of services, supports, and treatments. The goal is to enable people to enjoy a meaningful life in their community and exercise all their rights as citizens, while striving to achieve their full potential. Recovery principles, including hope, self-determination, and responsibility, can be adapted to the realities of different life stages, and to the full range of mental health problems and mental illnesses. Recovery is being embraced by policy makers, service providers, and practitioners in Canada and around the world.

Working with stakeholders and champions across the country, from grassroots to governments, the MHCC's Recovery Initiative has the potential to accelerate recovery-oriented approaches. Its impact is expected to extend beyond mental health systems to include sectors such as justice and education, among others.



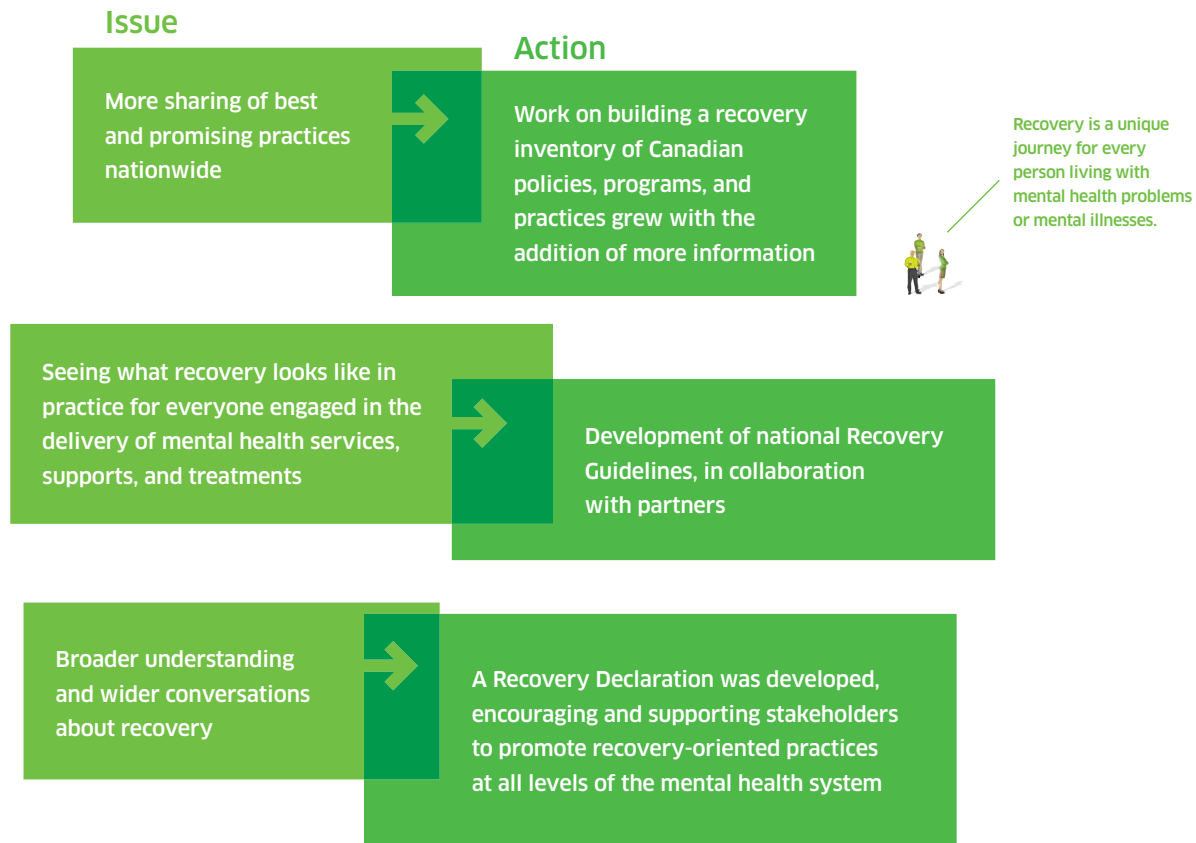
Foster wellbeing for people of all ages living with mental health problems and mental illnesses, and uphold their rights.”

– **Strategic Direction 2**
Mental Health Strategy
for Canada

The Pan-Canadian Recovery Initiative

Adopting recovery-oriented practices will enhance health outcomes and quality of life for people living with mental health problems and mental illnesses and their families. The MHCC is committed to working with all stakeholders to make recovery and recovery-oriented services a reality across the country. The Recovery Initiative will facilitate this change by:

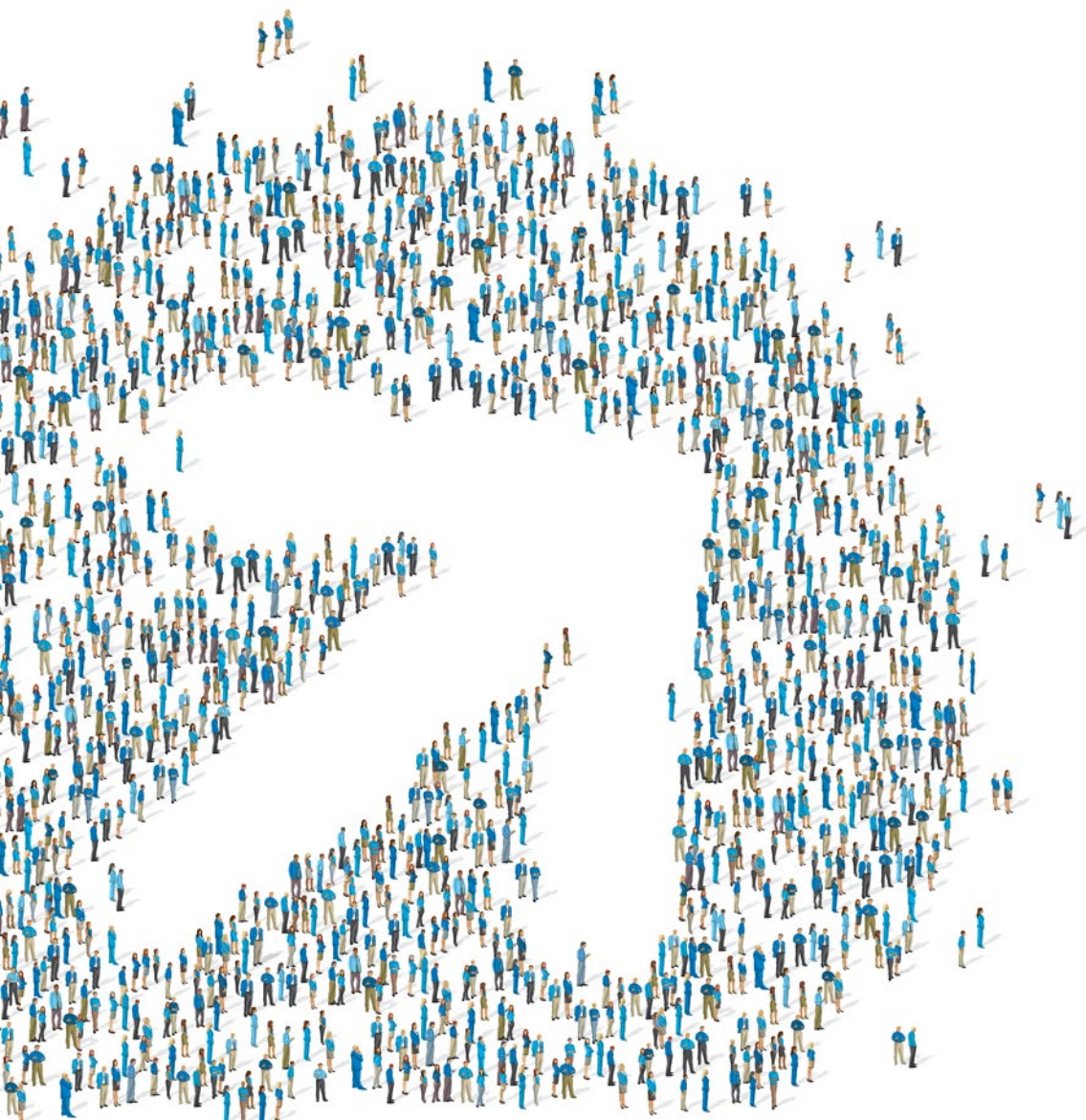
- > Sharing and showcasing leading and promising practices through the development of an online inventory of recovery-oriented resources
- > Enabling ongoing dialogue on recovery and building momentum by promoting a Declaration of Commitment to Recovery
- > Developing recovery guidelines to encourage and guide implementation across the mental health system.



Recovery: Additional Highlights from 2013–14

- To ensure the Recovery Inventory is as comprehensive as possible, a broad survey of stakeholders was completed.
- Collaboration was strengthened through a Memorandum of Understanding with PSR Canada, outlining key areas for working together, notably developing Recovery Guidelines while supporting the pioneering work of PSR Canada in advancing recovery.
- Increasing the awareness and implementation of the Strategy, including recovery, prompted the MHCC to sponsor two special issues of the *Canadian Journal of Community Mental Health*, and to prepare the call for the submission of papers.
- The MHCC, with its Youth Council, began work on a youth friendly version of the Strategy, in which the principle of recovery is central, to best support the mental wellbeing of children and young people.
- Maintaining its role as an active partner, the Commission continued to take part in the development of the Canadian Depression Research and Intervention Network (CDRIN).
- The conversation about mental health continued with stakeholders and governments in all provinces and territories.





At Home/Chez Soi: Opening More Doors to Better Mental Health

When people have the security of a home, it's possible to address mental health problems and mental illnesses and profoundly change lives. This is the future a Housing First approach can create – and research by the Mental Health Commission of Canada is making it possible.



IN 2013-14, the research phase of Canada's landmark five-year At Home/Chez Soi project concluded and proved that Housing First is a model that is highly adaptable, extremely successful, economically viable, and delivers real results. Displaying strong support, the Government of Canada announced a five-year, \$600 million extension of the Homelessness Partnering Strategy to Housing First, citing the At Home/Chez Soi research.

During the At Home/Chez Soi project, the Housing First model was rigorously tested and undertook the seemingly radical step of addressing first and foremost the need for permanent shelter and the security that comes with it for people who are

chronically homeless and who live with serious mental health problems or mental illnesses. It was found that when participants were housed, physical and mental health supports and services could be more effectively addressed.

These results led to continued provincial investment as the At Home/Chez Soi project's five sites moved into and completed a one-year post-project transition phase. The Housing First programs in Toronto and Winnipeg are continuing, and ongoing access to housing subsidies and supports for participants who are currently housed in Moncton, Montréal, and Vancouver are confirmed.

5 year

research phase of At Home/Chez Soi completed. Findings led to five-year, \$600 million extension of the Homelessness Partnering Strategy to Housing First by Government of Canada

Scaling Up Housing First in Canada

Building on the Commission's methodology of identification of innovative practices, evaluation, prototyping of the best, and scaling up, At Home/Chez Soi provided a solid evidence base upon which to expand Housing First across Canada. In 2013-14, the Commission was an active leader on several key fronts to ensure continued uptake of this important evidence-based policy.



Issue

Offering training and technical assistance to effectively roll out Housing First through the federal Homelessness Partnering Strategy



Action

Developing an approach, in partnership with Pathways to Housing, and training 14 Housing First trainers as well as offering on-site training in two communities that engaged more than 200 participants from 18 communities

Strengthening Canada's housing and homelessness network



Engaging with national organizations and bringing together key partners in a conversation about social finance and opportunities related to Housing First and affordable/supportive housing

Providing tools to advance Housing First across the country



Finalizing and disseminating the Housing First Toolkit and ensuring it is broadly available

Advancing policy change to move toward a Housing First approach

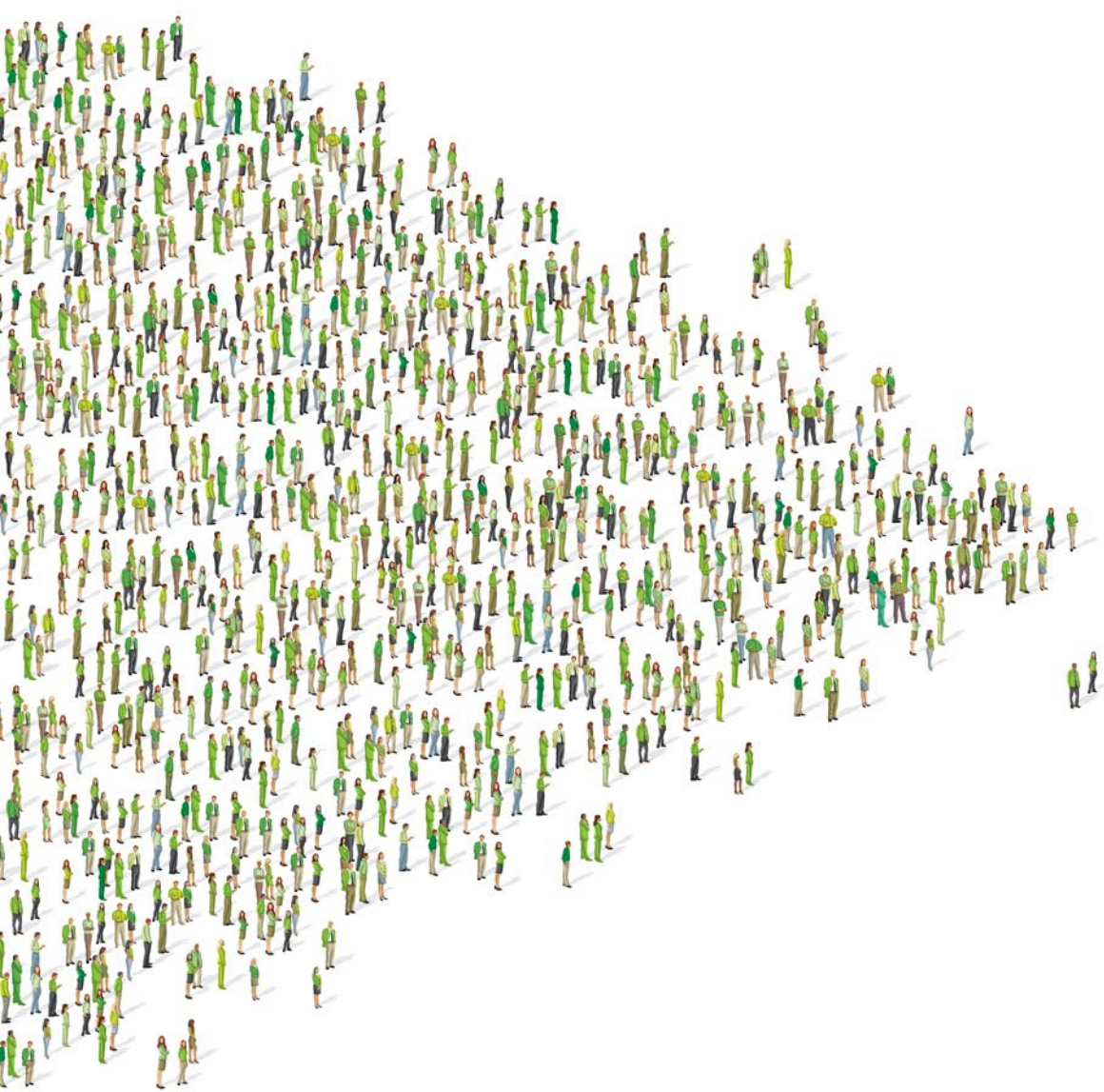


Hosting a half-day policy forum with senior officials from New Brunswick, the Yukon, Northwest Territories, Newfoundland and Labrador, Prince Edward Island, British Columbia, Manitoba, Alberta, Ontario, and the federal government

Housing: Additional Highlights from 2013-14

- Serving as a hub for Housing First information, the MHCC engaged with groups including the Canadian Housing and Renewal Association, Canadian Alliance to End Homelessness, Homelessness Hub, and the Wellesley Institute.
- Awareness and understanding was advanced by:
 - > publishing some 20 papers (with more than 55 papers and book chapters in print, and an additional 45 papers planned and in development)
 - > undertaking more than 25 national and international speaking engagements
 - > completing six site knowledge exchange activities, including full-day forums in Moncton and Montréal
- Summarizing At Home/Chez Soi so that learnings can be widely shared, the cross-site national final report and five site-specific final reports were completed and delivered to Health Canada.
- Facilitating an Aboriginal/First Nations Housing First training event was undertaken in partnership with the Homelessness Partnering Strategy.
- Supporting the investment in Housing First by the Homelessness Partnering Strategy, the Commission offered policy support and targeted training and technical assistance.





Knowledge Exchange Centre: Unleashing the Power of Knowledge

Knowledge informs policies and actions that improve mental wellbeing across Canada and around the world. This is what is possible when knowledge is shared and mobilized.



In 2013-14, the KEC helped meet the global thirst for knowledge related to mental health through digital and social media.

RESEARCH AND INFORMATION has its greatest impact when shared widely, and the Commission's Knowledge Exchange Centre (KEC) plays a vital role in ensuring that innovation moves to implementation quickly and efficiently. Its activities centre on finding avenues that enable new and existing evidence and information – including the work of the MHCC and its many stakeholders and partners – to be put to the best use to create meaningful, sustainable change across Canada and around the world.

In 2013-14, the KEC helped meet the global thirst for knowledge related to mental health by capitalizing on the potential of online and social media to bring people and ideas together. A strategic overhaul of the MHCC website was launched in April 2013, making a world of mental health information available around the globe. Focus on social media has seen an increase in

the number of friends and followers with thousands of impressions each week.

The KEC also brought 40 people from eight provinces together with international experts to fuel collaboration at the second annual SPARK (Supporting the Promotion of Activated Research and Knowledge) training institute in summer 2013. The first evaluation and impact report on SPARK activities is set for release in the coming year.

While trying to improve and promote knowledge exchange practices within Canada, the MHCC has realized the value of increasing the ability to connect people, ideas, and resources on a global level. As such, it jointly envisioned the formation of the International Knowledge Exchange Network for Mental Health (IKEN-MH) with the International Initiative for Mental Health Leadership (IIMHL).

IKEN-MH was formally launched in July 2012 with participants from Canada,

the United States, New Zealand, Sweden, Australia, Ireland, and the United Kingdom. The KEC was instrumental in bringing these groups together and in the development of the Network. The group met a second time in March 2013 as part of an IIMHL meeting held in New Zealand.

IKEN-MH presented on the successful collaboration between New Zealand and Canada on the creation of the SPARK training program at the Global Implementation Science Conference in Washington in August 2013. It will also be commencing a webinar series in 2014 in which the MHCC will take a lead role.

The Network is currently supported by a steering committee comprised of knowledge exchange leaders from seven countries, including the MHCC's KEC, and more than 70 members globally. The MHCC is the co-chair of the Network, and supports all of its endeavours.

Connections Ignite Dialogue

The launch of the new MHCC website in early April 2013 and the site's Collaborative Spaces initiative in October 2013 have garnered immediate and positive responses. MHCC's Collaborative Spaces is quickly becoming a national and international online repository and conversation place for mental health in Canada on issues such as mental health and the law, children and youth, e-mental health, peer support, caregiving, and suicide prevention, among many other topics.

Similarly, the MHCC's social media connections increased significantly over the same time period (a 20 per cent increase in the number of Twitter followers and 27 per cent increase in the number of Facebook page likes), ranking highly when compared to similar national not-for-profit organizations. The numbers continue to grow.

mentalhealthcommission.ca

31,000

visits per month



4,372

Twitter followers



3,850

Facebook page likes

3 minutes per
web page
(vs. the usual
1 minute
with typical
web pages)



KEC: Additional Highlights from 2013–14

- Building a strong foundation for evidence-informed mental health policy and practice in Canada, the KEC continued to lead the MHCC's Data Project. The initiative advances the *Mental Health Strategy for Canada* and will give every jurisdiction in Canada indicators against which progress in transforming the mental health system can be measured.
- Sharing knowledge and accelerating worldwide change, the KEC provided strategic advice and leadership to Tepou in New Zealand, which plans to replicate the SPARK model, and presented on the successful collaboration at the Global Implementation Science Conference in Washington, D.C.
- To better meet the mental health needs of diverse communities, the KEC facilitated a roundtable on diversity.
- Launched several new publications and resources, including:
 - > *SPARK Evaluation Report*
 - > *National Caregiving Support Guidelines*
 - > *A Foundation for Online Knowledge Mobilization in Child and Youth Mental Health*
 - > *Peer Support Guidelines*
 - > *School-Based Mental Health and Substance Use Consortium Final Report*

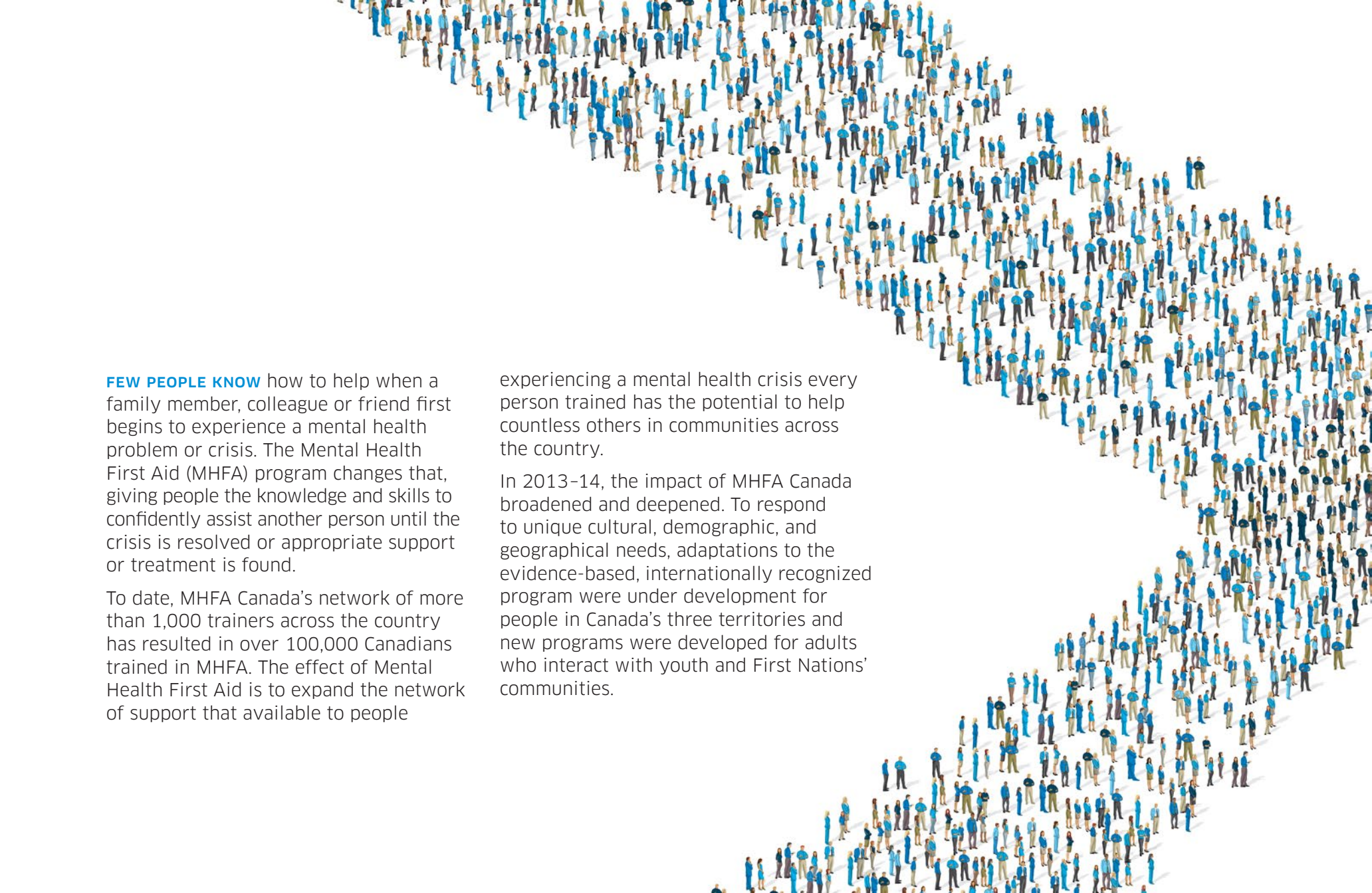




To date, 100,000 Canadians
have been trained in Mental
Health First Aid.

Mental Health First Aid (Canada): Increasing Canadians' Confidence and Ability to Help

The Mental Health First Aid (Canada) program changes more and more lives every year, ensuring that health care providers, family members, co-workers, and friends know how to help someone experiencing a mental health crisis.



FEW PEOPLE KNOW how to help when a family member, colleague or friend first begins to experience a mental health problem or crisis. The Mental Health First Aid (MHFA) program changes that, giving people the knowledge and skills to confidently assist another person until the crisis is resolved or appropriate support or treatment is found.

To date, MHFA Canada's network of more than 1,000 trainers across the country has resulted in over 100,000 Canadians trained in MHFA. The effect of Mental Health First Aid is to expand the network of support that available to people

experiencing a mental health crisis every person trained has the potential to help countless others in communities across the country.

In 2013-14, the impact of MHFA Canada broadened and deepened. To respond to unique cultural, demographic, and geographical needs, adaptations to the evidence-based, internationally recognized program were under development for people in Canada's three territories and new programs were developed for adults who interact with youth and First Nations' communities.

Adaptations Mean More Canadians Will Get the Support They Need

By adapting the MHFA program to meet distinct needs of specific populations, the Commission is able to effectively develop programs that are highly responsive and meaningful.



Issue

People who live in Canada's North are gaining a greater awareness of mental health issues and support for emerging mental health problems is being enhanced

Action

Mental Health First Aid for Northern Peoples is developed for people in Canada's three territories, celebrating the richness of life in the north while recognizing the realities of living in an isolated part of the country with limited access to mental health services

First Nations' communities have access to a culturally safe curriculum that recognizes historical issues and the mental health problems faced by First Nations people

Mental Health First Aid for First Nations is developed and is being launched in partnership with Aboriginal communities and mental health experts across Canada, and will feature ongoing consultation with those communities

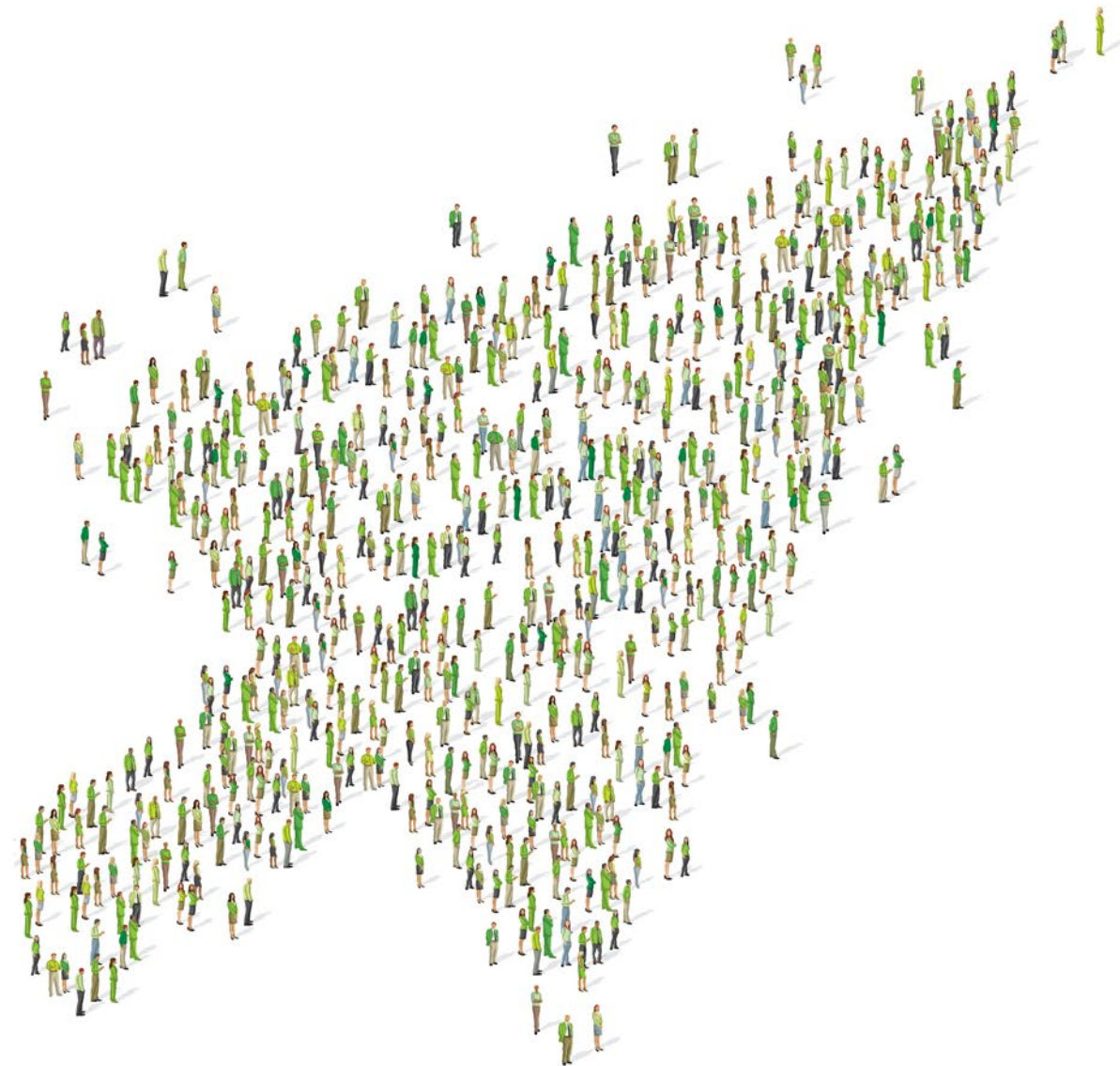
First responders in Newfoundland have new training, skills, and insights to better respond to youth experiencing mental health crises

Mental Health First Aid for Adults who Interact with Youth is made available by the Royal Newfoundland Constabulary (RNC) and Bell Aliant Pioneers for 4,500 RNC, RCMP, fire services, and EMT personnel

MHFA (Canada): Additional Highlights from 2013-14

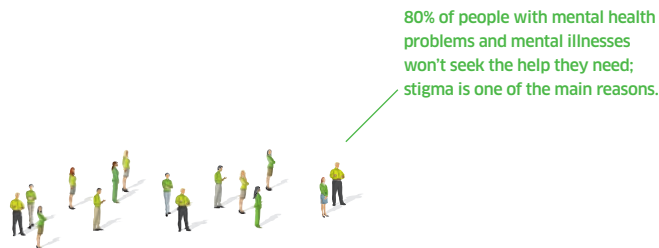
- More health care practitioners gained access to the basic MHFA course, which was accredited by the nursing faculty of Université de Montréal. MHFA meets the standards of the 72,000-member Order of Nurses of Québec and the continuing education requirements of the nursing faculty.
- Advancing the implementation of MHFA was accelerated through numerous conference presentations to key groups, including: the Public Health Agency of Canada; National Teachers' Union national workplace training group; Ontario Council for International Cooperation Global Citizens Forum; and, Canadian Federation of Mental Health Nurses.
- Promoting wider adoption of MHFA, the successful **Workplace First Aid Includes Mental Health** campaign that engaged more than 150 large and small organizations across the country in conversations about training Canadians in MHFA.
- Partner support helped move the Mental Health First Aid for First Nations program forward, with funding from the National Aboriginal Youth Suicide Prevention Strategy at the First Nations and Inuit Health Branch of Health Canada providing for further testing and curriculum finalization.
- An adaptation of MHFA for Seniors gained momentum, as the Commission worked in partnership with Trillium Health Centre to customize the program for launch in December 2014.
- A program adaptation for Inuit is in development and is scheduled for finalization in 2014-15.





Opening Minds: Putting an End to Stigma

When the Mental Health Commission of Canada and its partners nation-wide open minds about mental health, Canadians begin to put an end to the discrimination and stigma often associated with mental health problems and mental illnesses, and more people seek and receive the help they need.



OPENING MINDS, in partnership with some 110 organizations, aims to reduce discrimination by changing negative behaviours and attitudes often associated with mental health problems and mental illnesses. To date, it has evaluated some 50 anti-stigma programs across Canada to identify those that are effective and can be replicated, focusing on four primary audiences: healthcare providers, youth, the workforce, and media. Promising practice programs include Ontario Shores, the Durham Talking About Mental Illness program (youth), and the Department of National Defence's Road to Mental Readiness (workplace).

In 2013-14, the Commission entered a new phase, successfully transitioning from "creating knowledge" to "creating change." Four years of Opening Minds anti-stigma research is informing the promotion and launch of programs that will enable quick uptake on anti-stigma initiatives that have the potential to improve the mental wellbeing of tens of thousands of Canadians every year.

110+

strategic alliances
developed to reduce stigma

50 anti-stigma
programs
evaluated
across
Canada

Building on What Works for Greater Impact

Healthcare providers

The Practice Support Program (PSP) developed by the British Columbia Medical Association was replicated in Nova Scotia in 2013-14 as part of a randomized control trial. More than 100 family physicians are participating in the study which is designed to improve patient care and reduce stigma. An earlier B.C. study showed doctors reported greater confidence in treating patients with mental health problems and mental illnesses.

Youth

A national youth anti-stigma initiative that is set to launch in November 2014, based on Opening Minds research into most promising practices, and following an evidence-informed approach. With a focus on contact-based education, the initiative includes training for community organizations and schools, a national youth event in November, and up to 30 follow-up regional summits across Canada. Toolkits, a microsite, and webinars augment training for participants.

Workplaces

The Working Mind, a new anti-stigma/mental health education program, was developed by the MHCC in collaboration with the Department of National Defence (DND). A significant number of employers in sectors across Canada are participating in pilot testing. The Road to Mental Readiness (R2MR), an anti-stigma/mental health program based on the work of the DND, was also developed for police personnel. Eight municipal police service agencies, a provincial police college, and the RCMP in New Brunswick are in various stages of adopting R2MR.

Media

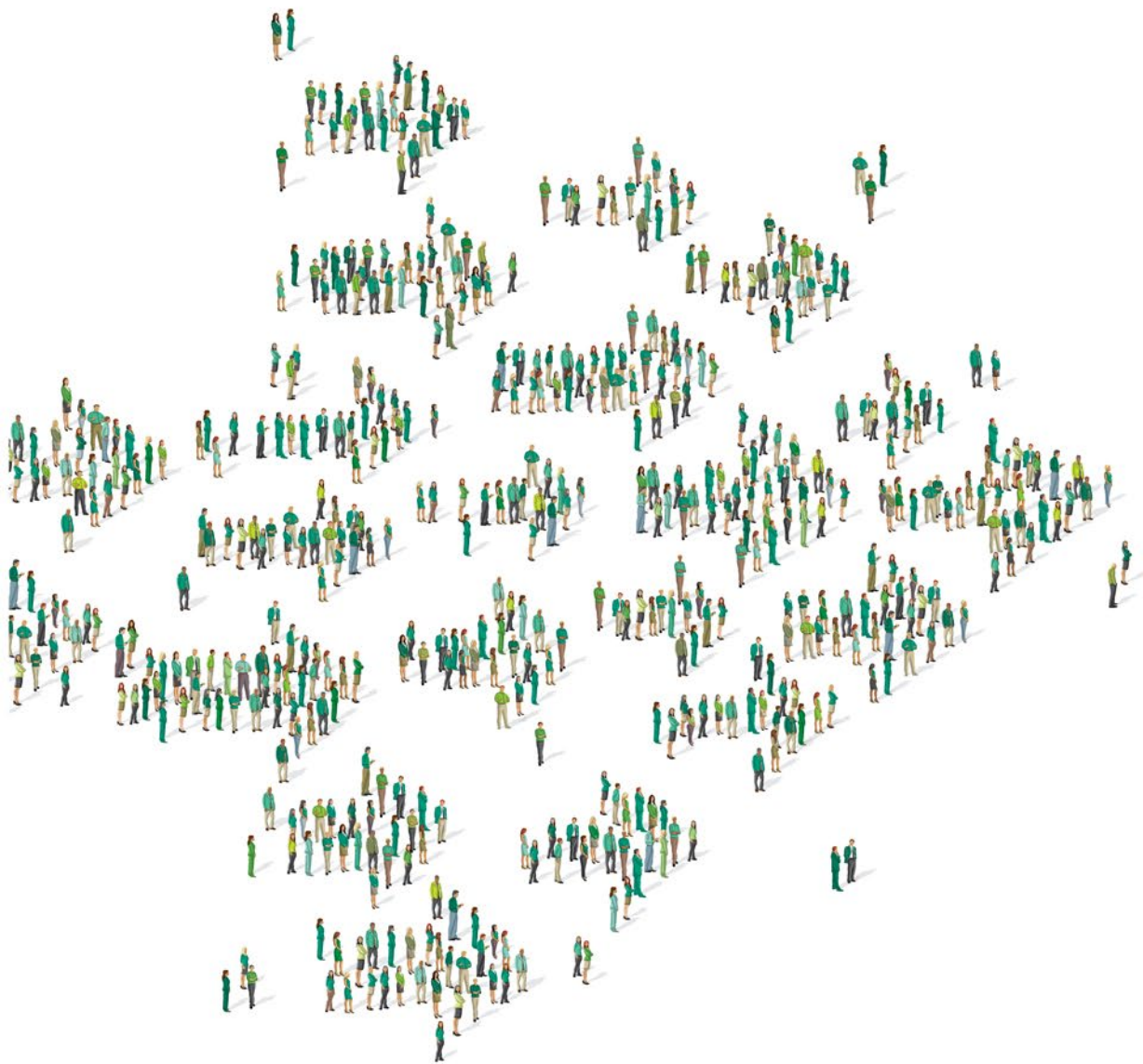
Mindset: Reporting on Mental Health, a news media resource guide and website, was launched in April 2014. It was developed by the Canadian Journalism Forum on Violence and Trauma, in partnership with the CBC and the MHCC. The foundation was also laid for an online anti-stigma program for journalism students and schools, which will be completed in the fall of 2014.



Opening Minds: Additional Highlights from 2013–14

- Anti-stigma research outcomes and best/promising practices were shared through a number of MHCC webinars. As well, the Understanding Stigma program and Cognitive Behavioural Interpersonal Skills training were delivered by Alberta Health Services.
- As a key outcome of the *Together Against Stigma* conference, hosted by the MHCC's Opening Minds in 2012, the Global Alliance Against Stigma was formed. A report, *Together Against Stigma*, was also made available during this time period.
- The **Understanding Stigma** program – which will be delivered widely among healthcare providers to help reduce stigma – was delivered to facilitators at the Vancouver Island Health Authority.
- Outlining the steps taken by successful programs, the Opening Minds' Youth Research Team developed a **Youth Key Ingredients Process Model**.
- Opening Minds contributed to scientific literature, including papers published in nine professional journals. [i.e. *Opening Minds Stigma Scale for Health Care Providers (OMS-HC): Examination of psychometric properties and reliability*, published in *BMC Psychiatry*]. Additional papers are in review.





Workplace Mental Health: Psychological Wellbeing is Job #1

Workplaces everywhere transform when a national standard becomes the norm and the mental wellbeing of employees is an organizational imperative.



Mental health problems
and mental illnesses cost
the Canadian economy
\$50+ billion annually.

MOST ADULTS SPEND MORE WAKING HOURS

in the workplace than anywhere else, making the work environment a prime influencer of mental wellbeing – and a Commission priority.

There is a strong economic argument* for continued investment in mental health. In 2011, one in five Canadians, or more than 6.7 million people, were living with a mental health problem or a mental illness.* It is estimated that mental health problems and mental illnesses already cost the Canadian economy \$50 billion each year.* By 2041, it is anticipated 8.9 million people in Canada will live with a mental health problem or a mental illness* and the annual cost of mental health problems and mental illnesses will reach \$307 billion each year.*

Fortunately, the MHCC has been able to demonstrate that this is a problem that has solutions. It is estimated that for every 10 per cent of people living with mental illness who enter recovery over the next 10 years, our economy will save \$4 billion per year.* Systematic efforts to promote mental health, prevent mental illness, and improve mental health services will save our country billions of dollars each year.

Canada's first *National Standard for Psychological Health and Safety in the Workplace* (the Standard) was released in 2012, and since then awareness of mental health issues in the workplace generally, and of the Standard in particular, has increased dramatically. This combination of new guidelines

and heightened profile is quickening changes in workplaces across Canada.

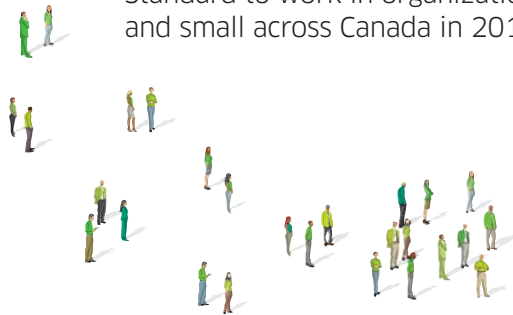
In 2013-14, the MHCC focused on encouraging organizations to implement the Standard. By April 2014, it had been downloaded free of charge more than 18,000 times, and an animated video explaining how to use it is the most popular on the MHCC's YouTube channel.

In January 2014, the MHCC launched a groundbreaking three-year National Standard Case Study Project, reflecting the organization's emphasis on best practices and knowledge exchange. An impressive 43 organizations from various sectors and regions across Canada have signed on to take part.

**Making the Case for Investing in Mental Health in Canada (2013)*

Putting the Standard to Work

The MHCC, along with its partners and stakeholders, focused on putting the Standard to work in organizations large and small across Canada in 2013-14.



Issue

Creating more mentally healthy workplaces



Action

Advancing implementation of the National Standard by hosting roundtables and forums, presenting a monthly webinar series, speaking at conferences, producing collateral material, and generating media coverage. The Standard was downloaded more than 18,000 times.

Focusing on gathering evidence for the Standard



Building a strong business case for Canadian employers to adopt the Standard by launching a three year national Case Study Project to gather evidence on promising practices and tools/resources useful for employers. More than 40 champion organizations are participating.

Helping to support people with severe mental illness



Sharing knowledge through initiatives such as the release of the *Aspiring Workforce: Employment and Income for People with Serious Mental Illness* report, published by the MHCC in collaboration with the Centre for Addiction and Mental Health, the University of Toronto, and Queen's University. The report offers practical advice for policy makers on how to improve employment and income for people with serious mental illness.

Motivating rapid workplace change



Inspiring workplace mental health ambassadors by promoting and profiling champions of workplace mental health that support mental wellness and use the Standard via video testimonials, speaking engagements, and other outreach activities.

Workplace: Additional Highlights from 2013–14



- In January 2013, the MHCC launched its three year Case Study Research Project at a packed media conference in Toronto (see photo page 10). In an MHCC video shown at the event, Canadian actor and mental health champion Mary Walsh shared the need for workplace mental health and the National Standard. To showcase workplaces that are implementing the Standard, five videos were produced. An online tracking form was also developed to better profile and engage champions of workplace wellness.
- Established a free monthly webinar series focused on different aspects of the Standard, with presentations from subject matter experts and employers adopting the Standard. Approximately 200 people participated in each webinar.
- Gathering further evidence for the Standard by launching a focused study to examine whether and to what extent employers are seeing the Standard as a means of averting conflict and legal action in relation to psychologically unsafe workplaces and mentally injurious behaviour.
- Encouraging the use of the Standard, the MHCC worked closely with HealthCareCAN (formerly the Canadian Healthcare Association) to develop and release a policy statement endorsing the Standard and encouraging its use by healthcare organizations across Canada.
- Further facilitating adoption of the Standard, work continued with hundreds of public, private, and not-for-profit organizations across Canada, as well as key influencers.
- The Standard has proven to be adaptable to a variety of contexts both in Canada and internationally. For example, the Commission supported the Tristan Jepson Memorial Foundation as it developed guidelines for psychological health and safety for legal professionals in Australia, based on the Standard.
- A collaboration with Excellence Canada highlighted mental health in the workplace with the creation of an award for Mental Health at Work (the MHCC was subsequently awarded the silver level in 2013 for its own work in adopting the Standard and creating a psychologically healthy and safe workplace).

1. Activities to encourage adoption of the *National Standard for Canada for Psychological Health and Safety in the Workplace* included a set of videos, such as one featuring popular Canadian actor Mary Walsh using one of her characters to explain the merits of psychological safety on the job (see the MHCC's YouTube channel).

2. On October 7, 2013, MHCC President and CEO Louise Bradley (pictured here with Alison LeClaire Christie, Canada's deputy permanent representative to the United Nations) attended the mhGAP Forum in Geneva. Bradley participated in a review of the World Health Organization's Comprehensive Mental Health Action Plan 2013-2020.

3. Shayne Ramsay, BC Housing CEO, and Louise Bradley, MHCC President and CEO attended the Canadian Alliance to End Homelessness' National Conference in October 2013.

4. In March, Terry Coleman, MOM, PhD, spoke at a conference jointly sponsored by the MHCC and the Canadian Association of Chiefs of Police focused on improving interactions between police and persons with mental illness. Together with Dorothy Cotton, PhD, C.Psych, Dr. Coleman will author *TEMPO: Police Interactions—A report towards improving interactions between police and people living with mental health problems*, to be released in summer 2014.



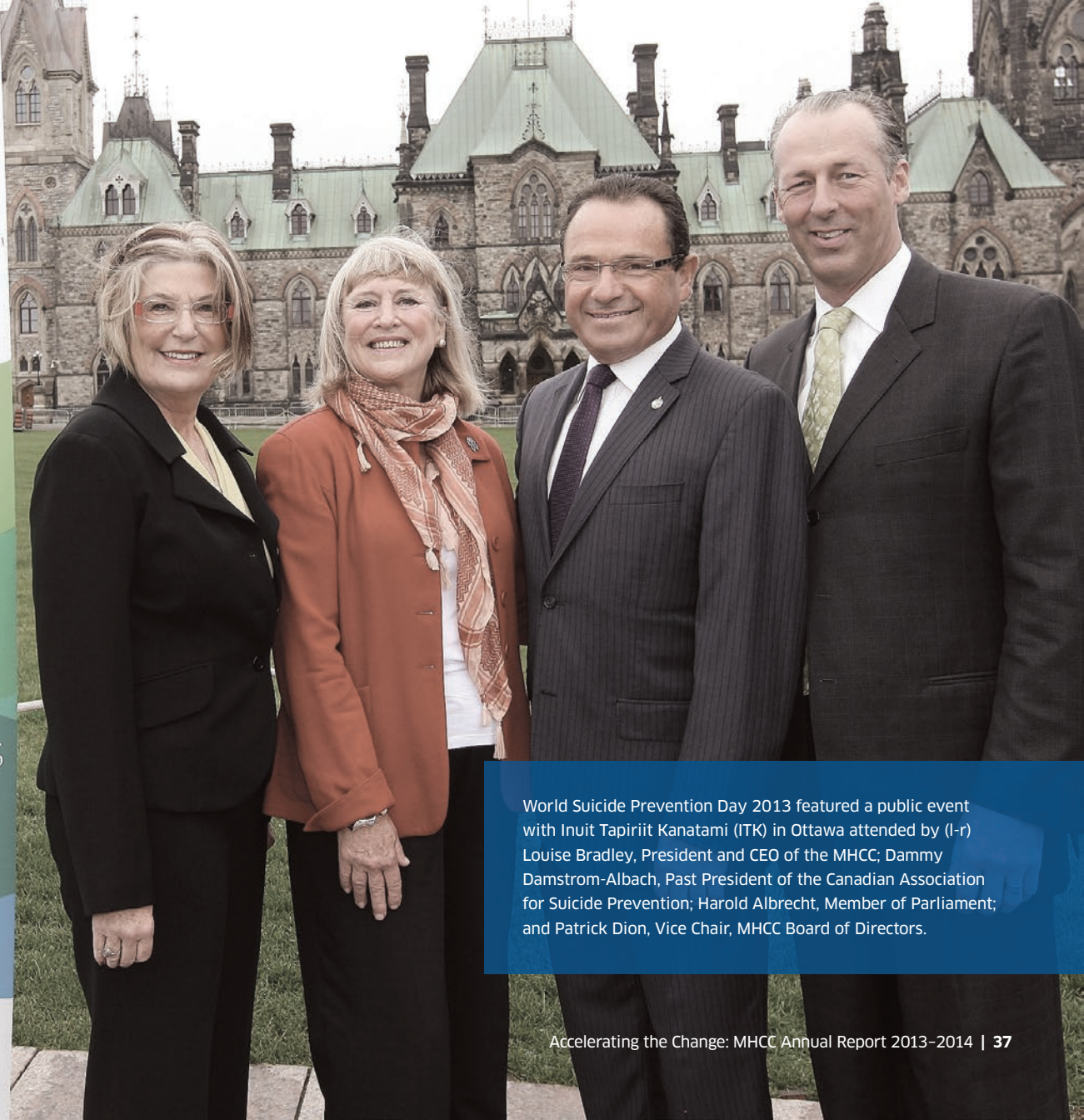


Mental Health
Commission
of Canada

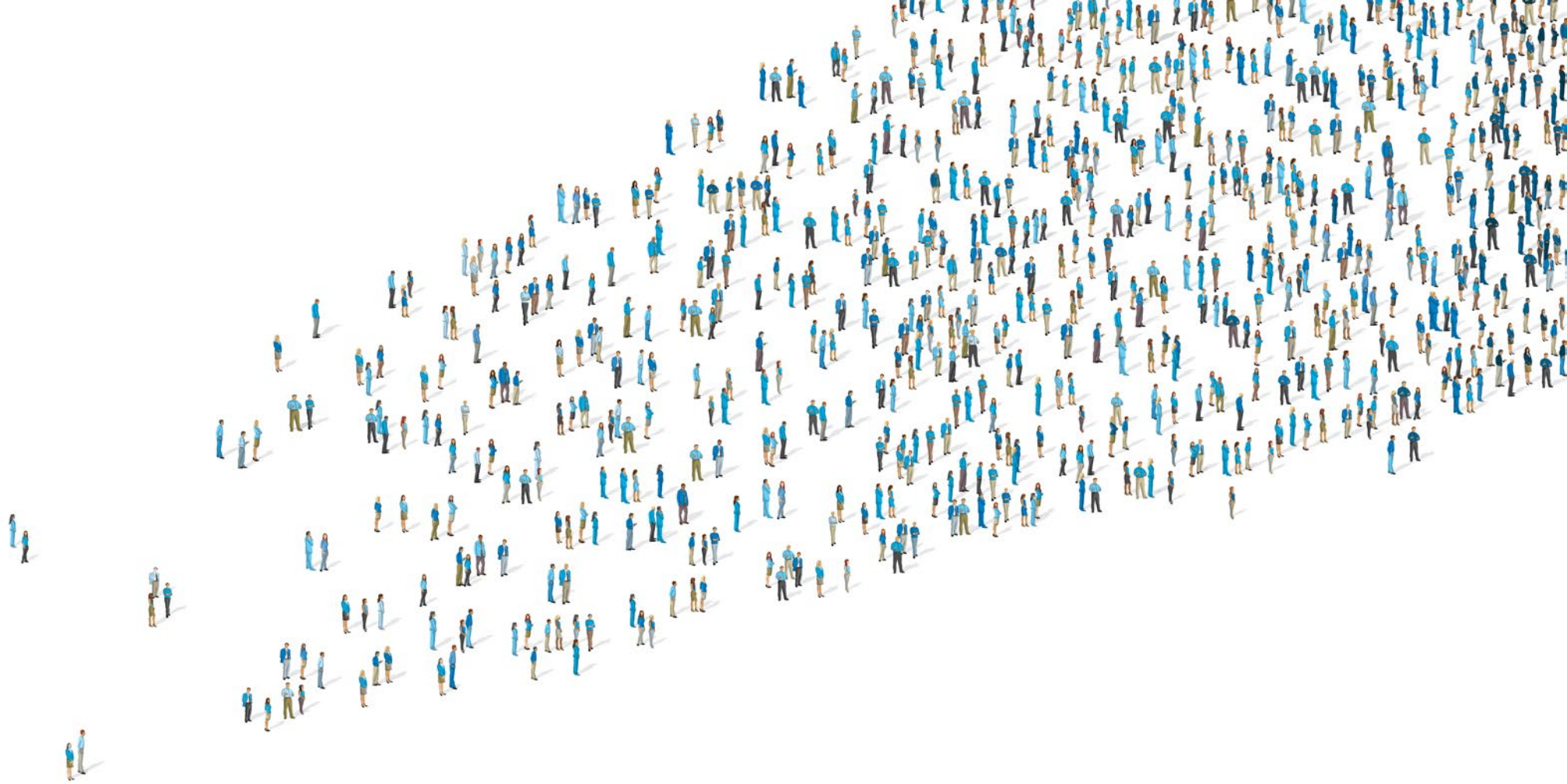
Commission de
la santé mentale
du Canada

Together we spark change
Ensemble, nous accélérons
le changement

mission.ca



World Suicide Prevention Day 2013 featured a public event with Inuit Tapiriit Kanatami (ITK) in Ottawa attended by (l-r) Louise Bradley, President and CEO of the MHCC; Dammy Damstrom-Albach, Past President of the Canadian Association for Suicide Prevention; Harold Albrecht, Member of Parliament; and Patrick Dion, Vice Chair, MHCC Board of Directors.





Together We Accelerate the Change

Canadians have come a long way in their attitudes and approach to mental health. It was not long ago that mental illness was a taboo and a heavily stigmatized topic in our country. More than ever, Canadians want to see change in our mental health system.

Changing Directions: Changing Lives, The Mental Health Strategy for Canada, released in 2012 by the MHCC, was built on in-depth and far reaching conversations with individuals, community and national agencies, healthcare organizations, family caregivers, people with lived experience of mental health problems and mental illnesses, governments at all levels, and stakeholders from coast to coast to coast.

Just as the Strategy was the work of many, the ongoing work to improve the mental health system in Canada cannot be not done in isolation. The MHCC plays a vital role in coordinating the work of citizens, organizations, advocates, service providers, and governments. It is only by harmonizing our efforts and working together that we will create better mental health for all Canadians.

Financial Statements

Year ended March 31, 2014

Independent Auditors' Report to the Members of the Mental Health Commission of Canada



We have audited the accompanying financial statements of Mental Health Commission of Canada which comprise the statement of financial position as at March 31, 2014, the statement of operations and changes in net assets and cash flows for the year then ended, and notes, comprising a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian accounting standards for not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material

misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, these financial statements present fairly, in all material respects, the financial position of Mental Health Commission of Canada as at March 31, 2014, and its results of operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Chartered Accountants
June 25, 2014
Calgary, Canada

Statement of Financial Position

March 31, 2014, with comparative information for 2013

	2014	2013
Assets		
Current assets		
Cash and cash equivalents	\$ 1,301,752	\$ 2,751,186
Short term deposits (note 3)	8,215,835	14,109,070
Contract advances	-	631,623
Accounts receivable	497,044	47,180
GST receivable	778,973	806,741
Deposits and prepaid expenses	299,942	104,723
Inventory	60,222	81,259
	11,153,768	18,531,782
Capital assets (note 4)	1,660,151	856,783
	\$ 12,813,919	\$ 19,388,565

	2014	2013
Liabilities and Net Assets		
Current liabilities		
Accounts payable and accrued liabilities	\$ 1,648,101	\$ 4,552,414
Deferred program fees	144,022	44,820
Deferred contributions – operating (note 5)	7,673,841	12,873,758
	9,465,964	17,470,992
Deferred capital contributions (note 6)	1,660,151	856,783
Net assets	1,687,805	1,060,790
Commitments (note 7)		
	\$ 12,813,919	\$ 19,388,565

See accompanying notes to financial statements

On behalf of the Board:



Director, David Goldbloom



Director, Patrick Dion

Statement of Operations and Changes in Net Assets

Year ended March 31, 2014, with comparative information for 2013

	2014	2013
Revenues:		
Grant income (note 5)	\$ 19,797,540	\$ 40,659,959
Mental Health First Aid income	2,092,900	1,284,510
Interest and other income	192,647	80,074
Amortization of deferred capital contributions	691,009	814,921
	22,774,096	42,839,464
Expenses:		
Direct client services (note 9)	1,125,650	23,298,210
Salaries and benefits	8,581,250	7,971,042
Services	6,821,991	4,698,451
Travel	1,709,186	1,728,432

Statement of Cash Flows

Year ended March 31, 2014, with comparative information for 2013

	2014	2013
Cash provided by (used in):		
Operations:		
Excess of revenues over expenses	\$ 627,014	\$ 70,618
Items not affecting cash flows:		
Amortization of deferred capital contributions (note 6)	(691,009)	(814,921)
Amortization	691,009	814,921
	627,014	70,618
Net change in non-cash working capital balances:		
Contract advances	631,623	(229,605)
Accounts receivable	(449,864)	409,064
GST receivable	27,768	9,741
Deposits and prepaid expenses	(195,219)	4,905
Inventory	21,037	(25,886)

	2014	2013
Expenses (continued):		
Rent	\$ 878,869	\$ 872,877
Meetings and events	853,774	1,195,419
Materials	1,485,352	2,189,494
Amortization of capital assets (note 4)	691,009	814,921
	22,147,081	42,768,846
Excess of revenues over expenses	627,015	70,618
Net assets, beginning of year	1,060,790	990,172
Net assets, end of year	\$ 1,687,805	\$ 1,060,790

See accompanying notes to financial statements

	2014	2013
Net change in non-cash working capital balances (cont'):		
Accounts payable and accrued liabilities	\$ (2,904,313)	\$ (619,675)
Deferred program fees	99,202	11,745
	(2,142,752)	(369,093)
Investing:		
Redemption of investments	-	17,654,091
Purchase of short term deposits (net)	5,893,235	(6,144,575)
Purchase of capital assets (note 6)	(1,494,377)	(65,227)
	4,398,858	11,444,289
Financing:		
Deferred contributions spent	(19,797,540)	(40,740,033)
Deferred contributions received	16,092,000	19,062,128
	\$ (3,705,540)	\$ (21,677,905)
Decrease in cash and cash equivalents during the year	(1,449,434)	(10,602,709)
Cash and cash equivalents, beginning of year	2,751,186	13,353,895
Cash and cash equivalents, end of year	\$ 1,301,752	\$ 2,751,186

See accompanying notes to financial statements

Notes to the Financial Statements

Year ended March 31, 2014, with comparative information for 2013

1. Description of the business:

The Mental Health Commission of Canada (the “Commission”) was incorporated on March 26, 2007 under the Canada Corporations Act and was continued under the Canada Not-for-Profit Corporations Act on June 25, 2013. The Commission’s mandate is to:

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

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

The Commission is funded through Contribution Agreements (“Funding Agreements”) with Health Canada. The first agreement calls for \$110 million over the five years ended March 31, 2013. An extension was given on the Contribution Agreement to March 31, 2014. This extension allows for any deferred revenue related to the \$110 million at March 31, 2013 to be used in the following year. Health Canada has also confirmed that the \$2.3 million in interest income from

the investments of the original grant can be used in 2014. As noted in above (d), the purpose of this initiative is to study best practices in addressing mental health and homelessness. The other agreements which call for \$5.5 million of contributions to March 31, 2008, and \$121.8 million over the nine years ending March 31, 2017, relate to the other initiatives described above. The contributions are subject to terms and conditions set out in the Funding Agreements.

2. Significant accounting policies:

- (a) Financial statement presentation:
The financial statements have been prepared in accordance with Canadian accounting standards for not-for-profit Standards in Part III of the CPA Handbook.
- (b) Revenue recognition:
The Commission follows the deferral method of accounting for contributions. Restricted contributions are recognized as revenue in the year in which the related expenses are incurred. Unrestricted contributions are recognized as revenue when received or receivable if the amount to be received can be reasonably estimated and collection is reasonably assured. These financial statements reflect arrangements approved by Health Canada with respect to the year ended March 31, 2014.

Interest income on investments is recorded on the accrual basis. Restricted investment income is recognized as revenue in the year in which the related expenses are incurred. Unrestricted investment income is recognized as revenue when earned.

The Commission earns service revenue related to first aid courses. Fees that are paid up front prior to the delivery of services are deferred and then recognized during the period the service is delivered.

(c) Cash and cash equivalents:

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

(d) Short term deposits:

Short term deposits consist of amounts held in interest bearing short-term investments, maturing within 12 months.

(e) Inventories:

Inventories are recorded at the lower of cost and net realizable value, with cost determined on a first-in first-out basis.

(f) Contract advances:

Contract advances arise from commitments to service providers under direct services contracts pertaining to the Commission's research initiative for the mentally ill and homeless for services to be provided.

(g) Capital assets:

Capital assets are recorded at cost and are amortized over their estimated useful life or until the end of the Commission's current grant agreement (March 31, 2017), whichever is earlier, on a straight-line basis using the following estimated useful lives:

Assets	Useful Life
IT infrastructure	5 years
Software	2 years
Office equipment	5 years
Furniture	5 years
Leasehold improvements	over the term of the lease

(h) Financial instruments:

Financial instruments are recorded at fair value on initial recognition. Freestanding derivative instruments that are not in a qualifying hedging relationship and equity instruments that are quoted in an active market are subsequently measured at fair value. All other financial instruments are subsequently recorded at cost or amortized cost, unless management has elected to carry the instruments at fair value. The Commission has not elected to carry any such financial instruments at fair value.

Transaction costs incurred on the acquisition of financial instruments measured subsequently at fair value are expensed as incurred. All other financial instruments are adjusted by transaction costs incurred on acquisition and financing costs, which are amortized using the straight-line method.

Financial assets are assessed for impairment on an annual basis at the end of the fiscal year if there are indicators of impairment. If there is an indicator of impairment, the Commission determines if there is a significant adverse change in the expected amount or timing of future cash flows from the financial asset. If there is a significant adverse change in the expected cash flows, the carrying value of the financial asset is reduced to the highest of the present value of the expected cash flows, the amount that could be realized from selling the financial asset or the amount the Commission expects to realize by exercising its right to any collateral. If events and circumstances reverse in a future period, an impairment loss will be reversed to the extent of the improvement, not exceeding the initial carrying value.

(i) Use of estimates:

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the period. Estimates include the valuation of contract advances and accounts receivable and the recoverability and useful life of property and equipment. Consequently, actual results may differ from those estimates.

3. Short term deposits:

Short term deposits consists of \$8,215,835 (2013 – \$14,109,070) in GIC's that mature in less than one year and have an average interest rate of 1.10% (2013 – 1.22%).

4. Capital assets:

March 31, 2014	Cost	Accumulated amortization	Net book value
IT infrastructure	\$ 910,010	\$ 460,524	\$ 449,486
Software	202,762	202,762	0
Office equipment	253,670	207,407	46,263
Furniture	664,354	530,323	134,031
Leasehold improvements	2,621,178	1,590,806	1,030,372
	\$ 4,651,974	\$ 2,991,823	\$ 1,660,152

March 31, 2013	Cost	Accumulated amortization	Net book value
IT infrastructure	\$ 492,711	\$ 280,549	\$ 212,162
Software	202,762	202,762	-
Office equipment	217,717	153,775	63,942
Furniture	631,269	399,222	232,047
Leasehold improvements	1,613,139	1,264,507	348,632
	\$ 3,157,598	\$ 2,300,815	\$ 856,783

5. Deferred contributions related to operations:

Deferred contributions include operating funding received in the current or prior periods that are related to the expenses of future periods and restricted contributions relating to the terms and conditions set out in the Health Canada funding agreements. Changes in the deferred contributions balance related to operations are as follows:

	2014	2013
Balance, beginning of year	\$ 12,873,758	\$ 34,616,890
Grants received	15,063,936	18,769,990
Grants received – MHFA	1,028,064	212,114
Less amount recognized as revenue	(19,797,540)	(40,659,959)
Amounts related to deferred capital contributions	(1,494,377)	(65,277)
Balance, end of year	7,673,841	12,873,758
Current Portion	7,673,841	12,873,758
	\$ -	\$ -

6. Deferred capital contributions:

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

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

	2014	2013
Balance, beginning of year	\$ 856,783	\$ 1,606,477
Capital contributions	1,494,377	65,227
Amounts amortized	(691,009)	(814,921)
Balance, end of year	\$ 1,660,151	\$ 856,783

7. Commitments:

The Commission rents premises under operating leases which expire in 2017. Minimum annual rental payments to the end of the lease terms are as follows:

2015	\$ 874,561
2016	710,765
2017	243,376
	<u>\$ 1,828,702</u>

The Commission has entered into contracts for services and research related to its initiative for those who are homeless and mentally ill and contracts related to other projects which support other initiatives which will be completed by 2014. Obligations under these contracts are as follows:

2015	\$ 750,000
	<u>\$ 750,000</u>

8. Indemnification:

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

9. Direct client services:

Direct client services pertain to the Commission's research initiative for the mentally ill and homeless.

10. Financial instruments and related risks:

Fair values:

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

Risk Management:

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

(i) Credit risk:

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

The Commission is exposed to credit risk on its accounts receivable from another organization. Concentration of credit risk arises as a result of exposures to a single debtor or to a group of debtors having similar characteristics such that their ability to meet contractual obligations would be similarly affected by changes in economic, political, or other conditions. The Commission monitors credit risk by assessing the collectability of the amounts. Of the accounts receivable at year end, \$480,323 (2013 – \$47,180) relates to accrued interest and other receivables.

The Commission is exposed to credit risk on its cash. The Commission manages this risk by ensuring compliance with the requirements of its Funding Agreement with Health Canada. Current investments are held in short term GICs. The Commission has determined that the maximum credit risk for accounts receivable is \$nil (2013 – \$nil).

Cash and cash equivalents consist of bank balances and short term deposits with large credit-worthy financial institutions.

(ii) Market risk:

The Commission is exposed to market risk on its investments. The Commission manages this risk by purchasing investments with maturities coinciding with planned cash requirements. The anticipated result of this intention to hold investments to maturity is essentially the elimination of this risk.

(iii) Interest rate risk:

Interest rate risk arises on cash and cash equivalents. The Commission is exposed to interest rate risk due to fluctuations in bank's interest rates.

The Commission does not hedge its exposure to this risk as it is minimal. Every 1% fluctuation in the bank's interest rate results in a \$13,018 (2013 - \$27,512) annual change in interest revenue.

The Commission is exposed to interest rate risk on its short term deposits. The Commission manages this risk by purchasing investments with fixed interest rates. As the Commission intends to hold its investments to maturity, fluctuations in interest rates will have no impact on how the Commission manages its investments.

(iv) Liquidity risk:

Liquidity risk is the risk that the Commission will be unable to fulfill its obligations on a timely basis. The Commission manages its liquidity risk by monitoring its operating requirements.

11. Comparative figures:

Certain comparative figures have been reclassified to conform with the financial statement presentation adopted for the current period.

Additional Management Information Homelessness Schedule of Expenses

For the year ended March 31, 2014

Expense by Cost Object:

Direct client services	\$ 1,125,650
Salaries and Benefits	877,763
Services	637,331
Travel	205,973
Occupancy	2,500
Meetings and Events	185,405
Materials	4,013
Administration	163,015
	<u>\$ 3,201,650</u>

Note 1:

Salaries and Benefits for the homelessness Initiative include \$162,670 for management team compensation in 2014.

Leadership and Governance

Board of Directors*

Dennis Anderson

Alberta

François Borgeat, MD

Hôpital Louis-H Lafontaine,
Québec

Lorraine Janet Breault, PhD

University of Alberta,
Alberta

Kim Calsafferri

Vancouver Coastal Health Regional
Mental and Addictions Program,
British Columbia

Uppala Chandrasekera (Vice Chair)

Canadian Mental Health
Association, Ontario

Manon Charbonneau, MD

Québec

Janet Davidson

Government of Alberta

Mike DeGagné, PhD

Nipissing University,
Ontario

Patrick Dion (Vice Chair)

Government of Ontario

Paul Glover

Health Canada,
Ontario

David Goldbloom, MD (Chair)

Centre for Addiction and
Mental Health, Ontario

Arlene Hache

Northwest Territories

Dana Heide

Government of the
Northwest Territories

Mark Henick

Canadian Mental Health
Association, Ontario

Karen Herd

Government of Manitoba

Barbara Korabek

British Columbia

Shan Landry

Saskatchewan

Michael Mayne

Government of
Prince Edward Island

Kevin McNamara

Nova Scotia

James Morrissey

Ontario

Peter Ralph

Government of
Newfoundland and Labrador

Cindy Stevens

Manitoba

Chris Summerville

Schizophrenia Society
of Canada, Manitoba

Fern Stockdale Winder

Commissioner, Mental Health
and Addictions Action Plan,
Saskatchewan

Glenda Yeates

Ontario

Executive Leadership Team**

Louise Bradley

President and CEO

Geoff Couldrey

Executive Vice President

Jennifer Vornbrock

Vice President, Knowledge and Innovation

Cameron Keller

Vice President, Programs and Priorities

Lawrence Green

Vice President, Corporate Affairs
and Chief Financial Officer

* Please note: Some Directors completed their terms during the fiscal year and others joined the Board mid-term.

** Please note: Some Executives did not serve for the full fiscal year.

Contact

Calgary Office Mental Health Commission of Canada

Suite 320, 110 Quarry Park Blvd SE,
Calgary, AB T2C 3G3

Tel: 403.255.5808
Fax: 403.385.4044

info@mentalhealthcommission.ca
www.mentalhealthcommission.ca

twitter @MHCC_
facebook.com/theMHCC
linkedin.com/company/mental-health-commission-of-canada
youtube.com/1MHCC

Ottawa Office Mental Health Commission of Canada

Suite 600, 100 Sparks Street
Ottawa, ON K1P 5B7

Tel: 613.683.3755
Fax: 613.798.2989

GET INVOLVED:



Production of this Annual Report has been made possible through a financial contribution from Health Canada.
The views expressed herein represent the views of the Mental Health Commission of Canada.





Mental Health
Commission
of Canada

Commission de
la santé mentale
du Canada

Together we accelerate the change
needed to transform the nation's
mental health system and improve
the mental health and wellbeing of all.

