



Chapter 5

Overarching Themes

Regional Dialogues participants and online workbook respondents (including members of the general public and representatives of stakeholder organizations) provided over 450,000 words of comments on the Commission’s proposed Framework. In addition to offering specific feedback on each of the eight proposed goals (as outlined in Chapter 4), participants also provided more general feedback on the Framework, identifying issues of concerns, gaps and other opportunities for strengthening the document.

This chapter elaborates on eight overarching themes, which emerged as recurring topics or ideas in a majority of the Regional Dialogues, as well as in the feedback collected online. They also surfaced as common threads across multiple goals.

It then presents other recurring issues and concerns heard in multiple Regional Dialogues and also seen in the online submissions. In closing, participants’ comments and suggestions on how to strengthen the Framework document (i.e., to make it more accessible to the public, more coherent and compelling) are summarized in table format.

Again, feedback from the Regional Dialogues and from the Online Consultations was generally congruent, although there were some differences in emphasis on certain topics (which is noted where applicable in the discussion that follows). Furthermore, given the format and duration of the Regional Dialogues, they generated more detailed input than did the online processes.

Overarching Themes

The following overarching themes emerged from participants’ comments on the eight proposed goals, as well as on the Framework document more generally:

1. Hope and recovery, which are pivotal to the achievement of a transformed mental health system, must be more systematically woven into the fabric of the Framework.
2. Holistic and person-centred approaches need to be centrally positioned within the Framework and integrated into all goals because without them, the mental health system will not be transformed.



3. The application of a social determinants of health (SDH) lens must be more clearly reflected in the revised Framework and goals.
4. The Commission must acknowledge First Nations, Inuit and Métis (FNIM) needs and realities through specific and explicit recognition within the Framework (*emphasized in Regional Dialogues*).
5. The Framework should reflect an understanding of the inherent tension between a) families as critical partners in prevention, promotion and recovery and b) the right of the individual to determine who his or her “family” is comprised of and the extent of their involvement.
6. The Framework and the Commission must stress the urgency of moving to implementation as quickly as possible.
7. The Framework should value and reference to a greater extent the diverse kinds of research and evidence needed to achieve and sustain a transformed mental health system.
8. To promote attitudinal and behavioural changes needed for transformation, the Framework must highlight the importance of informing and engaging all Canadians (*emphasized in Public and Stakeholder online comments*).

5.1 Hope and recovery, which are pivotal to the achievement of a transformed mental health system, must be more systematically woven into the fabric of the Framework

Despite calling for greater definitional precision and operational clarity around the concepts of hope and recovery, there was strong agreement among participants that these are pivotal to the transformation of the mental health system.

Notwithstanding, participants also cautioned against giving people the false hope that recovery equates to being “100% cured” (while agreeing that a cure is possible in many cases), or that it presupposes the possibility of prevention in all instances. To this end, participants felt that the Framework needed to be clearer in its acknowledgement of the impact of genetics on mental health, and the fact that it is not possible to prevent all of the myriad ways in which life circumstances may contribute or lead to mental health stresses.

The concept of “resilience” – both at the individual and community level – also emerged as an important related concept, which ought to be further emphasized in the Framework, particularly within the context of prevention and promotion strategies. For example, adopting strength-based resiliency approaches was seen to be effective in helping individuals and communities meet life’s challenges (which, as noted, cannot ever be completely eliminated). Acknowledging the role and importance of cultural values and



identity in helping to build and sustain resilience – especially in ethno-racial and Aboriginal contexts – also emerged as a recurring theme across Regional Dialogues.

5.2 Holistic and person-centred approaches need to be centrally positioned within the Framework and integrated into all goals because without them, the mental health system will not be transformed

The need to embed a holistic philosophy within the mental health system was reiterated in session after session, as well as online. From participants' perspective, to be holistic, the mental health system must address all dimensions of well-being. In particular, participants recommended that the Framework should include a fourth dimension – spirituality – to the other three dimensions of mental health: physical, mental, and emotional.

The role and importance of self-determination as another dimension of person-centred approaches was cited repeatedly and was linked to the equally important notions of identity and autonomy. The notion of self-determination also included the role and importance of broader collective and cultural self-determination, particularly in Aboriginal communities.

Related to the notion of self-determination was the need for people to be meaningfully empowered to make informed choices. The right to choose services and treatments is not meaningful, they argued, unless people are adequately informed about the implications (positive and negative) of different treatment options. Participants also noted the need to also recognize the right of persons living with mental health problems or illnesses to make mistakes – something, they said, which is part of the human condition for everyone, with or without mental health challenges.

In almost every Regional Dialogue, the importance of confidentiality, privacy and consent were noted as key foundational elements underpinning a person-centred approach and as fundamental rights that must be protected. However, participants also acknowledged that the operationalization of these rights is one of the most divisive issues in the mental health community, especially for families and family caregivers. While participants recognized and accepted the inevitable tensions around this issue (and the fact that these tensions aren't likely to disappear), they also agreed on the need to manage them as effectively and in as sensitive a way as possible.

Finally, participants emphasized the need to directly engage people with lived experience of mental health problems and illnesses throughout all phases of the Framework and Strategy development and implementation. This was seen as a critical requirement for imagining and building a person-centred mental health system.



5.3 The application of a social determinants of health (SDH) lens must be more clearly reflected in the revised Framework and goals

There was clear feedback across sessions, as well as online, that a social determinants of health (SDH) lens should be applied to the Framework document, and that this perspective be woven into all eight goals. Participants acknowledged that the Framework did reflect an understanding of the role and importance of social determinants of health, but felt that these references were not sufficiently sharp or explicit, and were not systematically applied throughout the document. In particular, participants saw a need for a stronger SDH emphasis within the framing of the cultural safety goal, recognizing the undeniable reality of power differentials, socioeconomic status, and discrimination.

Looking ahead to implementation, participants urged the Commission to ensure that social determinants of health approaches be explicitly recognized in the design, planning and delivery of services and programs. Participants were especially concerned that the basic needs of marginalized populations be fully taken into account. Economic barriers such as lack of decent affordable housing, employment and food were repeatedly referenced as being of equal, if not more impact, than mental health problems or illnesses themselves.

However, there was some divergence as to how far the Framework could and should tackle SDH issues. Some felt that the Framework itself (and ultimately the Strategy) could not tackle all of the underlying issues associated with social determinants of health, but could certainly join forces with others who have this mandate, as well as specifically address any discrimination embedded in programs and services that serve people with mental health problems and illnesses. Others were less satisfied with this approach, believing the Commission and its Framework and Strategy should elevate the importance of addressing these broad systemic factors.

In just over half the Regional Dialogues, there was a strong push to have the Commission place stronger emphasis on the use of legislation and human rights approaches to address social determinants of health issues, including discrimination and stigma.

5.4 The Commission must acknowledge First Nations, Inuit and Métis needs and realities through specific and explicit recognition within the Framework (*emphasized in Regional Dialogues*)

This theme emerged primarily from the Regional Dialogues, although a number of stakeholder online submissions did reference the need for explicit attention to First Nations, Inuit and Métis mental health needs, including specific mental health strategies.

In a majority of Regional Dialogues, including all three territorial sessions (Iqaluit, Yellowknife and Whitehorse), the unique and urgent needs of First Nations, Inuit and Métis peoples were identified, with



a call for separate treatment in the Framework. The rationale for this argument was that Aboriginal peoples in Canada, the country's original inhabitants, have to cope with historical and ongoing power imbalances and need to be treated distinctly from ethno-racial groups that have come to Canada.

Some participants advocated for inclusion of First Nation, Inuit and Métis needs as an additional new goal, while others preferred to have their explicit needs integrated into each of the goals. For example, in the Territorial sessions, there was a strong push to have the Framework explicitly identify the need to recognize (and compensate appropriately) the competencies of lay and peer mental health counsellors/advisors, especially those of Aboriginal background (such as Elders).

Another example illustrating how Aboriginal realities need particular attention emerged in discussion about the way in which the Framework dealt with the concept of “person-centred” approaches. While acknowledging that this is key to mental health transformation, there was at the same time a caution about needing to recognize the unique cultural role Aboriginal communities and extended families (which hold different meaning from non-FNIM communities) have in supporting individual identity, well-being and recovery.

5.5 The Framework should reflect an understanding of the inherent tension between: a) families as critical partners in prevention, promotion and recovery and b) the right of the individual to determine who his or her “family” is comprised of and the extent of their involvement

There was strong recognition of the very important role that most families can and do play in prevention, promotion and recovery. At the same time, participants made it clear that the Framework must also honestly reflect the reality that families can and do contribute to their members' mental health problems and illnesses.

Participant conversations and online feedback demonstrated a sophisticated and nuanced understanding of the complexity surrounding the role and types of families (diversity of families, diversity of roles, children living with parents with mental health problems or illnesses, adult children of older parents with mental health problems or illnesses, role of siblings, etc) with cautions about not over-generalizing or simplifying where and how “families” fit into the overall context of mental health issues.

There was also deep appreciation for the complexity of legal, social and ethical issues involved. Participants identified the need to exercise good judgment, while adhering to legal and regulatory requirements so that the spirit (as opposed to the letter) of the law is respected. They also noted that families can play an important information role, even when the individual with the lived experience has opted for little or no family involvement.



Nonetheless, the right of individuals living with mental health problems and illnesses to determine both who counts as “family” and the extent to which those “families” or peers will be involved was upheld. Instruments such as advanced directives were seen to be important in helping to deal with situations where the judgment of the individual may be compromised.

5.6 The Framework and the Commission must stress the urgency of moving to implementation as quickly as possible

Although Phase I of the Commission’s work clearly focused on setting the goals for a transformed mental health system (the “WHAT”), participants nonetheless seized the opportunity to provide substantive input on implementation issues (Phase 2 of the development of a pan-Canadian strategy on mental health will wrestle with how the goals can be implemented across the country).

There was a palpable feeling of urgency – a sense that the Commission needs to move as quickly as possible to implementation, and advocate strongly for funding that is commensurate with the need. The fact that governments have not yet acted on strong recommendations advanced in previous studies and research was referenced repeatedly, with a fervent wish that the Commission not be another disappointment.

This sense of urgency was fed by acute awareness of the huge gap between needed and actual investments in mental health prevention and promotion, especially in Aboriginal, remote and Northern communities and among disadvantaged segments of the population. Examples of funding gaps and under-funding included: child and adolescent mental health programs, housing/group homes, parenting coaching, counseling, respite care, financial supports for family caregivers, etc.

Participants zeroed in on a number of implementation-related challenges or barriers, including:

- huge funding gaps;
- lack of political will (because the issue is not perceived to be high on the public agenda);
- fear/ignorance of mental problems and illnesses;
- stigma and discrimination (many participants argued that the successful implementation of change will require legislative, regulatory and policy changes to directly combat discrimination);
- tensions between funding for promotion versus funding for treating illness;
- health human resource capacity gaps and training needs;
- the negative role played by the media; and



- the geographic size and diversity of country, etc.

Notwithstanding these challenges, in many sessions there were usually a number of participants who were encouraged by what they perceived to be growing public awareness and alignment of commitment across sectors.

Another challenge identified by online public and stakeholder participants was the need to strive for a balanced approach to addressing the competing demands within the mental health system, given limited resources. In particular, they cautioned against “robbing Peter to pay Paul.” While recognizing the severity and urgency of the needs of specific populations (for example, the homeless, low-income populations, Aboriginal groups, people in rural, remote and Northern communities), they also warned against meeting the needs of the few to the detriment of those of the many. Participants in the Regional Dialogues also spoke of the need for balance, for example stressing that an emphasis on prevention and promotion should not lead to the diversion of critical resources away from treatment.

Participants also called for the implementation strategy to explicitly include robust benchmarks or outcome measures that could be used to assess improvements and performance. These measures of success were variously referred to as benchmarks, sentinel indicators, accountability measures, and outcome targets. This call for measures was accompanied by the recognition that measuring effectiveness, outcomes and accountability in the mental health sphere can be more complicated and challenging than measuring health care outcomes.

Finally, mental health service providers were identified as key partners/players in achieving a transformed system. However, in order for them to fulfill this role, participants believed that personal, organizational and system-wide change was required. For example, participants noted that mental health workers often face stigmatization themselves within the health system, and are often at risk of burnout due to workload, under-funding, and lack of support and recognition. On the other hand, participants added, some mental health workers often unknowingly carry stigmatizing attitudes and exhibit discriminatory behaviours that can be damaging and hurtful for people who are dealing with mental health problems or illnesses. For these reasons, participants believed that professional education, training and support around mental health issues need to be ramped up.

5.7 The Framework should value and reference to a greater extent the diverse kinds of research and evidence needed to achieve and sustain a transformed mental health system

In general, participants perceived the underfunding of research on mental health issues to be a symptom of the broader societal neglect of mental health needs. Increased investment in research and outcomes measures was seen to be a priority, with the caveat that research not be “research for research’s sake”. Research, participants felt, must serve the needs of people with mental health problems and illnesses.



Some felt that the case for increased investments for research could be more effectively framed around arguments that speak to “cost effectiveness and return on investment” considerations.

Frustration was evident across sessions with knowledge transfer, and particularly the lag between when research is completed and its impact on policy, practice and service delivery. Some participants also expressed concerns that Canada had not adequately mined existing research knowledge to inform mental health policy and practices, as well as to educate the public and others outside the mental health system (e.g. educators, justice system, and employers). In a number of sessions, participants articulated the need for a standardized, computerized, easily accessible, national database that would include utilization and monitoring data in the area of mental health as a way to facilitate and accelerate knowledge transfer.

There was also a general call for more participatory research methods and the utilization and integration of diverse kinds of knowledge, including: traditional, Aboriginal, experiential, community-based, clinical and scientific knowledge. They advocated a valuing of both qualitative and quantitative methods and research practices that are independent, accountable and guided by ethical frameworks. For example, participants sought increased investment in research that connects communities, people with lived experience and their families, clinicians/front line health service providers and academic researchers. In the Northern sessions, participants expressed skepticism about who benefits from the research conducted and a view that communities and people living with mental problems and illnesses are treated as “objects” rather than participants in the research.

Finally, many felt that the Framework document should be strengthened wherever possible with additional research citations that included not just best, but also, promising practices and diverse types of evidence to substantiate key points.

5.8 To promote attitudinal and behavioural changes needed for transformation, the Framework must highlight the importance of informing and engaging all Canadians (emphasized in Public and Stakeholder online comments)

While this point did arise in the regional sessions, it was more pronounced in the online public and stakeholder responses. In particular, public online participants consistently noted that engaging Canadians, providing them with compelling information, personal stories and concrete suggestions for how to make a difference could change the way people think and act toward mental health issues.

Many noted the importance of making information on mental health problems and illnesses widely available in work and school environments. This would be an effective way to create positive attitudinal and behavioural changes, and would greatly assist in achieving any number of the proposed goals. Online stakeholder submissions focused on the powerful role of the voluntary sector in mobilizing public



support, the inclusion of recovery-oriented curricula within medical schools, the need for a mental health literacy campaign, and the importance of a media strategy.

Other Recurring Issues and Concerns

In addition to the eight overarching themes outlined above, participants also articulated a number of other important recurring issues and/or concerns that emerged across sessions and from their online comments. They add further insight into participants’ perspectives on the Framework document and are summarized in the table that follows (see Table 5.1).

Table 5.1: Other Recurring Issues and Concerns

Theme	Recurring Comments and Concerns
The Framework’s repeated reference to a “mental health system” in Canada is misleading.	<ul style="list-style-type: none">• The Framework document must acknowledge upfront that there is no such thing as an integrated “Canadian mental health system.” Rather, there is a patchwork of multiple provincial/territorial systems with significant variation in policies, programs and services.
Health human resource planning will require priority attention if a transformed mental health system is to be realized.	<ul style="list-style-type: none">• The Framework should place greater emphasis on the need for health workforce planning and development to ensure quality of services and address provider shortages. One of the end goals must be to ensure the availability of the “right health human resources, at the right place, at the right time, in the right roles.”• The Framework must recognize that many needed services are currently either not funded at all (not integrated within the formal public health care “system”), or grossly under-funded. Examples cited included:<ul style="list-style-type: none">- Public funding for clinical counseling and psychological services;- Recognition of the importance and contribution of non-accredited mental health workers (e.g., peer counsellors, elders, community-based mental health workers) and the role they could/should play in a transformed mental health system.



Table 5.1: Other Recurring Issues and Concerns (continued)

Theme	Recurring Comments and Concerns
<p>More emphasis on the importance of communities in transforming mental health is required.</p>	<ul style="list-style-type: none"> • The Framework should amplify the role of communities in prevention, promotion and recovery, and by extension, the importance of fostering healthy and resilient communities. This should include explicit recognition of the need for adequate funding and supports for community-based services. • The Northern dialogues highlighted the very unique challenges faced by Northern communities (e.g., isolation, food, housing, safety, cost of living, transportation) and their direct impact on mental health. Participants advocated that their realities be acknowledged in the Framework. In addition, in several sessions, the needs of Aboriginal communities located within provincial boundaries, were also identified.
<p>The challenges of operationalizing “the right of consent” requirements merits greater attention and discussion in the Framework.</p>	<ul style="list-style-type: none"> • A range of questions arose about the many challenges associated with “consent,” including: <ul style="list-style-type: none"> - How do mental health workers consistently define and enforce the “right” criteria? There is a need for flexibility, as there are no “one-size-fits-all” solutions, yet we must ensure we are not transgressing legal boundaries. - Can those with severe symptoms make safe decisions? How might advanced directives be used more consistently? - What are the rights of youth in the 12 to 18 age group? How do we define the rights of and respect the wishes of a “mature youth”?
<p>Addiction and substance abuse issues are not adequately addressed in the Framework.</p>	<ul style="list-style-type: none"> • There were recurring calls for the Commission to learn from the successes of, and create clear linkages with, the addictions and substance abuse movement, and to reflect this in the Framework. • Questions arose repeatedly about the inter-relationships between mental health issues and addictions/substance abuse issues, including uncertainty about the boundaries between addiction and mental health.



Table 5.1: Other Recurring Issues and Concerns (continued)

Theme	Recurring Comments and Concerns
<p>There were a variety of other issues identified that some participants felt required greater emphasis in the Framework (listed at right).</p>	<ul style="list-style-type: none"> • The inter-relationships between mental health problems, discrimination and poverty and the criminal justice system, and the need for collaboration across systems that are working to address these issues. • Gender-based analysis in both the Framework and goals, and in research, planning, design and delivery of mental health services. • Focused attention on the needs of children and youth and the importance of early intervention. • The positioning of employers as critical partners in changing practices and behaviours to support prevention, promotion and recovery (employer obligations, healthy workplaces, etc.) • The deleterious effects of self-stigmatization on persons living with mental health problems and illnesses, their families; and on mental health service providers.

Framework Coherence, Presentation and Language

Finally, participants in the Regional Dialogues and in the online processes provided very specific comments on ways to improve the coherence and presentation of the Framework, and on how to sharpen and clarify language – all with a view to making the document more precise, more effective and more accessible to a broad array of Canadians. Their feedback is summarized in the tables that follow (see Tables 5.2 and 5.3).

Table 5.2: Framework Coherence and Presentation

Coherence and Presentation	Recurring Comments and Concerns
<p>Revise the Framework’s language and style to make it more accessible to the public.</p>	<ul style="list-style-type: none"> • Conduct a plain language review and editing of the document to ensure it is accessible for a lay audience. • Include either a glossary of key concepts (e.g., “recovery,” “cultural safety,” “mental health system”) or integrated definition boxes within the body of the document. • Add a clear, succinct executive summary that includes the key “take-away” messages of the document.



Table 5.2: Framework Coherence and Presentation (Continued)

Coherence and Presentation	Recurring Comments and Concerns
<p>Make greater use of diagrams/graphic presentations.</p>	<ul style="list-style-type: none"> • Help readers grasp the interconnectedness and interdependence of the Framework goals • Better explain logic of the Framework • Make the document more accessible and engaging • Appeal to those who aren't text-based learners
<p>Make a clearer distinction between elements of a “vision” and “goals” (aspirational vs. directional statements)</p>	<ul style="list-style-type: none"> • Many participants questioned whether all 8 goals were indeed “goals.” In particular, many felt that goals 1 (Recovery), 7 (Eliminating Stigma and Discrimination) and 8 (Social Movement) could be reframed and repositioned as vision/aspiration/principle statements or preambles to the Framework, rather than as specific goals. • Others noted the need for greater consistency in the framing of goals (i.e. some are more aspirational, others are directional).
<p>Reconsider whether and how to order/number the goals.</p>	<ul style="list-style-type: none"> • While accepting that the goals are not prioritized in the Framework, participants urged the Commission to reconsider whether and how to order/number the goals. • Some recommended changing the order of the goals, for example, leading with Goal 5 (Access) given that it is well understood and highly supported. • Others suggested removing the numbering altogether.

Table 5.3: Framework Language

Language	Recurring Comments and Concerns
<p>Use bolder language and more compelling examples.</p>	<ul style="list-style-type: none"> • Replace the “bullying” and “stressful work environments” examples in the description of Goal 2 (“...and to reduce factors that increase the risk of mental health problems and illnesses – such as bullying at school and stressful work environments”) with more compelling examples, such as “toxic environments, sexual, emotional, physical abuse/violence”



Table 5.3: Framework Language (continued)

Language	Recurring Comments and Concerns
<p>A thorough review of the French-language version of the Framework is required.</p>	<ul style="list-style-type: none"> ● The French-language revision of the final Framework will require careful translation and revision by native French-Canadian speakers (both within and outside Quebec) to ensure both accuracy and cultural-appropriateness of language. ● There were numerous issues identified with the language and terminology used in current French translation (e.g., use “secteur communautaire” vs. “bénévoles,” use “logement” vs. “hébergement”).
<p>Consider alternatives for the term “cultural safety.”</p>	<p>Suggestions include:</p> <ul style="list-style-type: none"> ● Cultural sensitivity/understanding ● Cultural mindedness ● Cultural competence ● Culturally appropriate and safe ● Culturally affirming ● Culturally informed ● Diversity ● Emotional safety ● Respectful
<p>Clarify and nuance the use of the term “recovery” in the Framework.</p>	<ul style="list-style-type: none"> ● Given the importance of the term “recovery,” there was considerable feedback on the need for some revision in how the Framework uses this term. ● Some felt that greater nuance and qualification are called for, reflecting in part concerns about age-related distinctions, and differentiating “recovery” and “cure.” ● Others felt the concept of “recovery” needed to be accompanied by greater emphasis on notion of “well-being” and/or “resilience.” ● Still others wanted the emphasis to be placed on the notion of a “journey” of recovery.



Table 5.3: Framework Language (continued)

Language	Recurring Comments and Concerns
<p>Broaden the Framework’s definition of “family.”</p>	<p>Given sensitivities around the place of “family” within the mental health system, participants urged the Commission to define “family” more broadly within Framework. Terminology suggestions include:</p> <ul style="list-style-type: none"> ● Family of choice ● Circle of care ● Circle of support ● Natural helpers ● Natural supports ● Carers ● Extended family
<p>Where appropriate, use more positive (instead of negative) language and framing in depicting mental health problems and illnesses.</p>	<ul style="list-style-type: none"> ● There was general support for replacing the term “burden” of mental health problems and illness with a more neutral word. ● However, there was considerable discussion – but no consensus – on whether to use the term mental health “problems” or “issues.” Some felt that the former presented a negative tone, while others felt that “issues” was too vague.
<p>Broaden the concept of “evidence-based” research by including more nuanced and accurate terms.</p>	<p>Suggestions include:</p> <ul style="list-style-type: none"> ● Evidence-influenced ● Evidence-informed policy ● Evidence and values-based research ● Appropriate evidence that takes contextual factors into account ● Evidence informed by promising practices



Chapter 6

Closing Thoughts

It bears re-stating that the Mental Health Commission of Canada’s public consultation process on the draft Framework document ***Towards Recovery and Well-Being – A Framework for a Mental Health Strategy for Canada*** generated over half a million words of comments, and that almost 2,500 individuals participated in this process, from all corners of the country.

I would like the commission to really consider what has been said by all participants in this survey and treat everything very seriously. If there is a genuine desire to help promote good mental health and prevent bad mental health then the problems that have been addressed need to be taken very seriously [...]. I don't know how strongly I can put it to be heard but I certainly hope you will listen.

*Online Participant
Ontario*

More importantly, however, it is the enthusiasm of participants, their collective sense of hope, and the constructive spirit in which they offered their comments, which is most heartening. While participants were clear that much needs to change – and that change is urgently needed – they also applauded the Commission’s approach. In particular, they thanked the Commission for providing them with a meaningful opportunity to contribute to a national endeavour that affects them very directly and personally. However, they also gave voice to a strongly held conviction that words without action will achieve nothing. As such, they called on the Commission to be a true agent of change, and to ensure that their words will not be spoken in vain.

The next phase of the Commission’s work – articulating a pan-Canadian mental health strategy, and supporting implementation strategies – is no small challenge. However, the degree of congruence that emerged across different individuals, groups, and organizations who participated in this consultation process, especially given the volume and diversity of participants, attests to a emerging consensus and momentum, which the Commission must nurture and strengthen as it moves forward. Moreover, it also confirms that both citizens and stakeholders can and wish to contribute to the Commission’s work, and illuminates the value and pertinence of their contributions.

In closing, we turn to one participant’s story, which eloquently expresses the hope kindled by participants in this consultation process – a hope that they, in large part, entrust to the Mental Health Commission of Canada.



In their words...

Imagine

My perspective: Person living with a mental health problem or illness

Imagine walking into a room... it's bright and cheerful. There is someone there to greet you and who says to you "someone will be with you shortly". You sit down. The chairs are comfortable. There are plants and flowers all around, and posters on the walls say DREAM, IMAGINE, and HOPE. Within minutes, someone sits down with you and talks to you like you are a real person. You are offered something to drink. You don't sense that they are afraid of you.

Within a short period of time, you are talking about your needs. You are given time to talk. Do you need to be admitted to a hospital, you wonder? Is that an option because it is the only option for you to get your needs met? Can a support worker stay with you tonight at your home? Help you get home safely. What about someone who can bring you to a friend's house? Do you know what you need?

You may be afraid that someone is going to see you in this room, in this place. After all, you have a job and you don't want anyone to know that you have "problems". You get help quickly and you are offered a private room discreetly. There is also a door in the back where people will not see you leave. You don't have to go out in the waiting area crying because you are upset. And there is a place to have a cigarette, although you are embarrassed about that as well.

By the time you leave, you have a plan. It may be simple but you have one. You feel more in control. You know you can come back here at anytime, day or night. You are on a list for a counsellor and a counsellor can see you within the next 72 hours. Resources in the community are explained to you. Someone helps you call a support group. You can come here anytime. Watch TV. Read. Or do nothing. Sort out your thoughts. There is also a music room where others are relaxing, drawing and thinking. There are safe and comfortable spaces here.

You can talk to others if you like. You walk out after a meeting with the counsellor and feel respected, understood, and that you are not the problem, but that you have one, and that your problems can be solved and that there are people to help you solve it. This is the mental health system we dream of. Places people can go. To feel safe. To feel comfortable. To talk. What kind of mental health system do you want? Now is a time to dream and to imagine.
