Building for the Future

2017-2018
ANNUAL REPORT

Mental Health Commission of Canada
Commission de la santé mentale du Canada

Building for the Future – 2017-2018 Annual Report
Mental Health Commission of Canada, 2018

Ce document est disponible en français

This document is available at www.mentalhealthcommission.ca
Production of this document is made possible through a financial contribution from Health Canada.

ISBN: 978-1-77318-079-3 (e-book)
ISBN: 978-1-77318-078-6 (print)

Financial contribution from

Health Canada Santé Canada

MENTAL HEALTH
COMMISSION OF CANADA

BUILDING FOR THE FUTURE
2017-2018 ANNUAL REPORT

Table of Contents

03/ PROGRESS ON PRIORITY AREAS

04/ FINANCIAL STATEMENTS

01

Preamble

01/1

Letter from the MHCC President and CEO

The Mental Health Commission of Canada's (MHCC) 11th year has been spent building a bridge to the future. After a ten-year grant agreement, which saw the creation of the country's first mental health knowledge exchange center, the development of the nation's definitive mental health strategy and the conception of an award-winning anti-stigma program, the MHCC turned a page on a new chapter to zero in on a fresh set of priorities.

Four areas clearly delineated by Health Canada shaped the work undertaken by the MHCC in the first year of a new contribution agreement. With a focus on substance use and addiction, at-risk populations, suicide prevention and engagement, the MHCC embarked on an ambitious work plan featuring more than 60 projects. In addition, our training programs such as *Mental Health First Aid (MHFA)* and *The Working Mind (TWM)* continue to grow at an impressive pace.

During this busy transition, the Minister of Health struck an independent review to ascertain how the suite of Pan-Canadian Health Organizations could operate more effectively and work more collaboratively to advance the goals of a 21st century health care system.

It's clear that a refinement of the health organizations' mandates will mean more change at the MHCC. We welcome the opportunity to support any efforts to expand access to services and improve care for the more than 7 million Canadians living with a mental health problem or illness this year.

Discussions with policy makers, stakeholders, people with lived experience and healthcare providers tell us that a national mental health entity remains a valuable mechanism to exchange knowledge, promote best practices and knit together communities of practice in service to better care.

With these goals in mind, the MHCC has undertaken a range of projects that will serve as building blocks for a more vital, responsive and flexible learning health care system. Working at an organization during a time of change necessitates a re-affirmation of commitment from staff at every level.

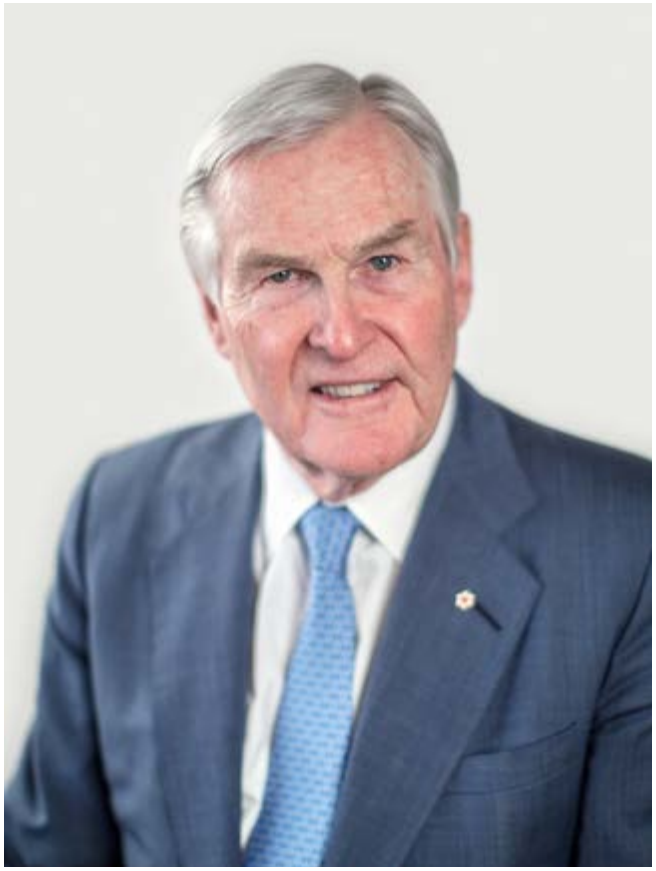
Regardless of the kind of work the MHCC is carrying out, the quality and integrity of our projects reflect the passion and expertise of the more than 80 staff members who put the advancement of mental health care at the core of their professional lives.

I could not work with a more committed group of people and am grateful everyday for their hard work and the hard-won progress that results.

Louise Bradley
President and CEO

01/2

Letter from the Board Chair



In my many years as an advocate for mental health in Canada, this decade has seen by far the greatest progress. I credit much of this success to the pan-Canadian coordinating efforts of the Mental Health Commission of Canada (MHCC).

Today, we are poised to see the promise of better mental health care come to fruition. But for that to happen, we need to continue the tremendous momentum built so far, and be wary of its greatest threat: complacency.

Stigma has abated, but it is by no means conquered. From allocation of resources, to inequitable access to services, we must knit together the fractious web of care in service to a more cohesive, consistent and collaborative safety net.

Fully one third of Canadians report an unmet need for mental health care. This litmus test that tells us we must go beyond reimagining a better system of care. It's time to get to work and rebuild.

> *I came to believe that health services ought not to have a price tag on them, and that people should be able to get whatever health services they required irrespective of their individual capacity to pay.*
>
> **– Tommy Douglas**

The MHCC is stepping in to do our part with efforts like *Roots of Hope*, a national suicide prevention project that is being rolled out in communities across the country. The same is true of *HEADSTRONG*, an anti-stigma program that nurtures resiliency and help-seeking among high school students – reaching them at a time when intervention is most likely to bend the cost curve across the lifespan.

We are also bridging gaps among vulnerable populations and addressing the concurrent challenges of mental health, substance use and addiction. From bringing together caregivers across the country, to brokering solutions to improve provincially funded psychotherapy, the MHCC is strengthening networks and amplifying stakeholder voices to create opportunities for advancing mental health.

There are no simple answers, which is why all the MHCC's work is rooted in tried and tested evidence. This extends to work we plan to undertake next year to examine the effects of cannabis on mental health, significant funding for which was allocated in the federal Budget 2018.

Improved mental health care in Canada requires a national voice to articulate need and hold sway with decision makers at all levels of government. It is easy to think that improved awareness is progress.

But until every person in the country has access to care when and where they need it – under the auspices of our publicly funded system – we will be falling short of a promise all Canadians have come to expect.

If we remain committed to the principal of an equitable system of care, we must expand the range of mental health care options, which have proven effective and cost-efficient, into the basket of services that fall under Medicare. Only then, will universal health care truly be achieved, and can we say, with conviction, that we are truly caring for the most vulnerable among us.

Michael Wilson

Board Chair

01/3 Introduction

The MHCC was created in 2007 to establish an ongoing national focus on mental health. The MHCC raises awareness of Canadians' mental health and wellness needs and accelerates collaborative solutions to mental health system challenges. A great deal of progress has been made in reducing the stigma around mental health problems and illnesses. However, much work remains, particularly to reduce institutional stigma and to ensure that mental health is well integrated with other health services. In addition, mental health promotion remains vitally important while suicide prevention requires urgent attention.

The MHCC's strategic plan has three broad objectives. These are to:

- Be a leading partner in increasing the effectiveness of Canada's mental health system by convening stakeholders, developing and influencing sound public policy, and inspiring collective action
- Advance *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*
- Mobilize knowledge by developing and sharing effective and innovative evidence-based practices

These strategic objectives are woven into all the projects in the MHCC's two-year work plan, which forms the basis of our funding agreement with Health Canada. The work plan is divided into the following four priority areas:

Substance Use and Addiction – We have initiated projects to respond to the opioid crisis and to understand the issues faced by healthcare professionals to better support their work.

Suicide Prevention – We are using a grassroots approach, working with communities and partners to identify priorities and best practices. We also are providing education to assist police and healthcare professionals who provide direct care to people at risk of suicide.

Population Based Initiatives – We are reducing stigma and addressing the mental health and wellness needs of at-risk populations, including first responders, youth, seniors, and others.

Engagement – We are engaging with health sector and non-governmental partners, as well as provinces, territories and individual Canadians to identify priorities, address data and research gaps, and support health research and knowledge exchange initiatives carried out in collaboration with federal and Indigenous partners. We are also conducting targeted outreach and awareness campaigns.

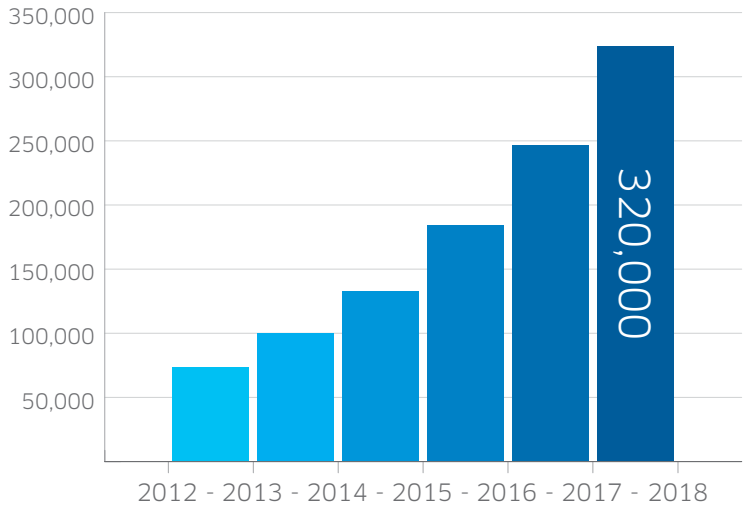
This report demonstrates our achievements during the first year of our two-year work plan. Many of our projects are ongoing and, as such, the positive impact of our work may only be seen once the projects have been completed and are widely implemented. Some of these activities will require years to bear fruit. The report also includes the 2017-18 financial statements and independent auditors' report and a list of knowledge products and partnerships. Select achievements of the MHCC's work over the past 12 months are reported in the annual highlights report for 2017-18.

02

Achievements at a Glance

The MHCC's activities have helped to improve services for people seeking mental health advice from their practitioner, have strengthened the ability of first responders to recognize their own mental health concerns and have led to improved help-seeking behaviour among students across the country. The MHCC has reached thousands of people across Canada.

02 Achievements at a Glance



Cumulative Number of MHFA Participants

77,000

Mental Health First Aid (MHFA) trainees in 2017-18 and

320,000

since we started training

107

speaking engagements
in 2017-18

5,500+

Road to Mental Readiness (R2MR)
trainees in 2017-18 and

85,500+

since we started training

13,800

The Working Mind (TWM)
trainees in 2017-18 and

30,000+

since we started training

In 2017-18 we held

15 *HEADSTRONG*

summits with

1,580

students attending

Since 2014 have held

58 *HEADSTRONG*

summits involving **916 schools**

with **9,130** students attending,

which impacts approximately

503,800

students at these schools

In 2017-18 we held

5 Indigenous focused

HEADSTRONG

summits with with youth from

42 First Nations

and Métis Communities

Since 2016,

there have been

9 summits that represented

55 First Nations

and Métis Communities

73,000+

newsletter recipients

in 2017-18

26 webinars attended by

3,300+ people

and **1,757** further views of these on our website this year

In 2017-18

1,800+

nurses, doctors and healthcare professionals

were trained in suicide prevention

In 2017-18 approximately

200 **first responders and supervisors**

trained in suicide prevention

with a total of **4,500** to date

03

Progress on Priority Areas

Like all employers responsible for maintaining healthy workplaces where individuals can thrive, Members of Parliament must be aware of, and sensitive to, the signs of those who may be struggling owing to a mental health challenge. The MHCC's mental health literacy training (Mental Health First Aid) is a valuable resource in providing Canadians with the insights and skills to fashion work environments where everyone can contribute positively and fully.

– Francis Scarpaleggia,
Liberal Caucus Chair and Member
of Parliament for Lac-Saint-Louis

03/1 Initiatives to Reduce Substance Use and Addiction

The MHCC has prioritized addressing problematic substance use and, specifically, the opioid crisis. From training and development to anti-stigma efforts, the MHCC is leading work to empower people in their communities and workplaces and to support health workers and first responders who are often the first point of contact in a crisis. We are also fostering improved understanding of the combined impact of mental health and problematic substance use to inform training development.

For example, the MHCC leads the Mental Health and Addiction Information Collaborative, a forum of seven national organizations that co-operate to align their initiatives to enhance mental health and addiction information and data in Canada. The Collaborative is facilitating efforts to integrate and improve existing data sources as well as develop new resources that fill mental health and addiction information gaps. The members have identified opportunities for increased cooperation and stressed the need to ensure that groups are not duplicating activities.

While progress has been made, stigma is still a major barrier that deters people living with addiction problems from seeking help, isolating substance users and their families.

Yet little is known about how to breach those obstacles. The Opening Minds Stigma Reduction Research for Opioid Addiction project has identified the learning needs of direct care providers who frequently interact with people living with these challenges. Having defined stigma related to opioid use/addiction among direct care providers and other first responders, the MHCC is exploring the development of tools to reduce stigma among this population. A literature review was completed and six regional focus groups were organized with first responders and people with lived experience, with an analysis of data from these proceedings. Three programs to reduce stigma among first responders have been identified and the three organizations running these programs have agreed to create/revise and evaluate a new survey tool as well as participate in MHCC research next fiscal year. An opioid specific version of the Opening Minds Scale for Healthcare providers will be developed in 2018-19 and a final report produced.

Physicians are well positioned to support people at risk for mental health and addiction problems, but they require screening guidelines and the ability to provide appropriate services, treatments and supports. The MHCC conducted a scan of existing training programs and identified key experts that could be engaged in the project. An expert roundtable was held in March with mental health and addiction leaders from across Canada who determined physicians' training needs related to mental health, substance use and opioids. Over the next year we will leverage this work to develop content for a bilingual mental health and addiction online training tool for physicians.

The substance use projects launched by MHCC this year are foundational initiatives that will build for future impact in 2018-19 and beyond once we have completed the products and launched them. The training will help to reduce stigma and allow healthcare providers to see beyond the addiction and treat the person. People often avoid seeking help from healthcare providers because of the stigma that they receive from providers.

03/2 Working with the Grassroots to Prevent Suicide

The alarming rate of youth suicide – the second leading cause of death among young people – and the climbing suicide rate over the past decade demands urgent attention. At least 4,000 people tragically die by suicide each year in Canada. The real number is likely much higher, given suicide is often under-reported due to stigma and concerns for the family. Up to 90 per cent of people who die by suicide were experiencing a mental illness at the time. A better understanding of the factors contributing to suicide, combined with evidence-based prevention programs, can reduce this number.

> MHCC's overarching goal is to understand what services work best and are most sustainable to prevent suicide. From there, the MHCC will develop evidence-based recommendations and accompanying tools and resources. *"We must take action to have the proper supports and services in place and this project is a step forward,"* says The Hon. Dwight Ball, Premier of Newfoundland and Labrador.

The MHCC continues to co-lead the development of a national suicide prevention research agenda with the Public Health Agency of Canada. The Research Priority Setting project is addressing the lack of alignment in research agendas across the country, which limits the opportunity to accelerate the use of research and innovation in suicide prevention. An environmental scan was produced, pinpointing research gaps, and consultation meetings took place in Halifax, Toronto, Winnipeg, Vancouver, Ottawa and Montreal that brought together researchers, service providers, people with lived experience and government policy makers to identify priorities. These priorities were used to inform an online questionnaire, to be released early next fiscal year, which will inform the final report on research priorities that will be produced next year. Setting common priorities will reduce duplication and support collaboration in the research community.

The MHCC is creating a network with provincial governments on a National Suicide Prevention Research Demonstration Project, called "Roots of Hope", to build tools for larger scale suicide prevention efforts. The project is researching and evaluating a community-based suicide prevention approach. Meetings with local community leaders, people with lived experience and decision makers were held in three of the confirmed sites to form community groups, identify priorities and develop community specific action plans. Public launches of the pilot projects took place in Newfoundland and Labrador as well as New Brunswick, and three additional sites have been confirmed in two provinces. There are active discussions with three additional sites interested in participating.

The MHCC is collaborating with key partners to identify, share and develop suicide prevention best practices for high-risk populations. The National Collaborative on Suicide Prevention met with 35 representatives from 24 organizations to share information, collaborate and explore topics such as truth and reconciliation, suicide and the opioid crisis, and safe language in suicide prevention. The MHCC hosted meetings in Vancouver to support a provincial strategy for suicide prevention among Lesbian Gay Bisexual Transgender Queer Two-Spirit (LGBTQ2+) people. The MHCC is also participating in the Canadian Foundation for Healthcare Improvement's Suicide Prevention/Life Promotion Collaborative Guidance Group to assist with its work with the Canadian Northern and Remote Health Network. The MHCC took part in events examining suicide prevention, such as the Family Medicine Forum and the Ordre des infirmières et des infirmiers du Québec congress. These knowledge translation efforts enable organizations to share information on current and future activities, to provide opportunities for collaboration, and to raise awareness of the importance and urgency of suicide prevention.

Stakeholders identified the need for increased knowledge and access to supports and resources for people who have been affected by suicide. A toolkit for Survivors of Suicide Attempt and a toolkit for Survivors of Suicide Loss and Postvention Professionals were developed in partnership with the Centre for Suicide Prevention, CASP and the Arthur Sommer Rotenberg Suicide and Depression Studies Program. The toolkits reflect a literature review completed by the Centre for Suicide Prevention, resources from both the Indigenous and Francophone communities, and a summary of the tools, resources and language that resonated the most with the hundreds of people who responded to a public call for input. A knowledge exchange plan is being implemented that includes a social media strategy, updates on the MHCC website and promotion of the toolkits at key venues such as Wisdom2Action, the LGBTQ2+ World Café in Vancouver, a webinar for the Newfoundland and Labrador Centre for Applied Health Research and a suicide prevention webinar on safety planning. These toolkits will help individuals affected by suicide or suicide attempts to find resources to talk about suicide, help them cope and support others.

> Research shows that those who die by suicide frequently had contact with a health care provider in the weeks and months prior to their deaths, yet, "*Coming out of medical school, doctors feel inadequately prepared to discuss the sensitive issue of suicide with their patients*" says Dr. Glenn Pearce, one of three family doctors who, along with two suicide experts, have developed online training on suicide prevention for family physicians.

Recognizing that direct care workers require training in suicide prevention, the MHCC partnered with the Federation of Medical Women of Canada and CASP to develop and promote online suicide prevention modules for healthcare workers.

By the end of March 2018, 1,826 physicians, nurses and other healthcare providers had a greater understanding of the warning signs, appropriate actions to prevent suicide and the necessity of reduced stigma.

In addition, a French-language version of a training module for first responders was developed, accredited and released in partnership with the Canadian Police Knowledge Network (CPKN). Approximately 3,500 first responders and 1,000 supervisors have completed the training to date (in both English and French).

As a leader in generating evidence and identifying best practices in suicide prevention, the MHCC is keen to share and exchange its knowledge through conferences and presentations. A knowledge exchange strategy has identified opportunities, such as participation in a panel discussion on community suicide prevention at the Canadian Mental Health Association (CMHA) Mental Health for All conference in September 2017. In addition, the MHCC attended conferences and hosted webinars on suicide prevention topics and has partnered with CASP to plan a national suicide prevention conference scheduled for Oct 31-Nov 2, 2018 in St. John's Newfoundland.

03/3 Addressing the Mental Health Needs of Various Populations

Canada has a diverse population, which means that mental health programs and services must be tailored to meet the distinct requirements of different groups. The MHCC is responding to the needs of those at greatest risk. The following are highlights of actions involving at-risk populations such as people with lived experience of mental health problems, Indigenous peoples, Lesbian Gay Bisexual Transgender Queer Two-Spirit (LGBTQ2+) individuals, youth, workers, healthcare providers, seniors, and racialized groups.

1. At-Risk Populations

Youth

Seventy per cent of people living with a mental illness report the onset of their mental health problems occurred during adolescence, yet more than two-thirds of young people will not seek help. Early intervention and treatment is critical and can make a dramatic difference in a person's quality of life. Post-secondary institutions are overwhelmed by demand for help they say they cannot meet. The 2016 National College Health Assessment found 59.6 per cent of students experienced feeling hopeless in the previous 12 months, while 44.4 per cent felt so depressed they could not function. Thirteen per cent seriously considered suicide and 2.1 per cent attempted it.

In response to this challenge, the MHCC developed *The Inquiring Mind (TIM)*, an adaptation of the successful *Road to Mental Readiness (R2MR)* program that reduces barriers to care, encourages early access to care, and provides tools and resources to improve mental health. *TIM* uses many

of the same elements as the *R2MR* program, such as stigma reduction, the mental health continuum and coping strategies, as well as contact-based education videos. *TIM* also deals with suicide and substance use and addiction. The program helps students to identify and cope with stressors and be more likely to provide – or seek – help. Fifty facilitators and more than 600 students have been trained at eight postsecondary institutions in Alberta and Atlantic Canada this year. The MHCC continues to receive requests for the program from other universities and colleges. This ongoing pilot study will have the first pre-post and post-post evaluation reports completed by the end of June 2018. Gender-based analysis of evaluation results will be conducted. Depending on the outcome of the study, *TIM* should be available for broader use by fall of 2018.

The *National Standard of Canada for Psychological Health and Safety in the Workplace* is a set of voluntary guidelines, tools and resources to promote mental health and prevent psychological harm in the workplace. The success of *The Standard* for the workplace led Bell Canada, The Rossy Family Foundation, and The RBC Foundation to approach MHCC to design and lead the development of the *National Standard of Canada for Psychological Health and Safety of Post-Secondary Students*. They have committed $1M in funding to the project and we have established more than 10 formal partnerships with community organizations, field experts, and research groups. The MHCC is in the planning stages and anticipates that the final product will be available in January of 2020. This resource will be a similar set of voluntary guidelines, tools and resources to promote mental health and prevent psychological harm in post-secondary educational settings.

Currently, there are few resources to help service providers understand how youth want to receive recovery-oriented care. Recovery approaches recognize that each person is unique with the right to determine his or her own path towards mental health and well-being. In addition, recovery-oriented care recognizes that many complex intersecting factors (biological, psychological, social, economic, cultural and spiritual) affect mental health and well-being.

The MHCC initiated a project to provide a "by youth" perspective to help service providers implement appropriate recovery-oriented practices with their youth clientele. Members of the MHCC's Youth Advisory Council drove this project, creating an animated video entitled *Food for Thought: A Youth Perspective on Recovery-oriented Practice* and a clinical discussion guide to help service providers understand their views of recovery-oriented practice.

A complete outreach strategy to engage providers was created and will be implemented over the coming year.

> *HEADSTRONG is about giving young people in every community in Canada the power to "Be Brave, Reach Out and Speak Up." The same opportunity I was given just a few years ago. I'm still riding the remarkable wave of that experience, and I'm more motivated than ever to stand up in support of mental health.*
>
> **– Patrick Hickey,**
> Youth Mental Health Advocate

Indigenous Peoples

The MHCC recognizes the critical importance of culturally-appropriate mental health services for Indigenous peoples and is committed to walking alongside Indigenous partners to identify and address gaps. The MHCC was invited to partner with the Inuit Tapiriit Kanatami (ITK) to support their priorities related to the National Inuit Suicide Prevention Strategy, which is being led by the ITK based on regional direction from local Inuit groups.

Mental Health First Aid (MHFA) programs strive to reduce stigma, encourage participants to provide support to others and encourage self-help. This year, we trained 911 participants in *MHFA First Nations* and 144 participants in *MHFA Inuit*.

Through our Opening Minds program, we coordinated *HEADSTRONG* training to teach secondary students how to reduce stigma and become mental health champions in their schools and communities by sharing stories of recovery from a mental health problem (contact based education) and providing concrete tools.

This year we coordinated five Indigenous focused *Headstrong* Summits, bringing the total to nine since 2016 and representing 55 First Nations. The first on-reserve summit took place in October 2016 on Siksika First Nation in southern Alberta for Treaty 7 youth. The first Métis summit took place in Edmonton. We engaged in knowledge exchange through a webinar entitled "Travailler ensemble, Premières Nations, Inuit, Métis". Internally, the MHCC has staff that focus on working with Indigenous partners, is hiring additional staff and provides ongoing training in cultural competency to all staff. The MHCC has also engaged in capacity building through enhanced outreach to Indigenous peoples to increase their participation in *SPARK* and other activities.

Seniors

With Canada's rapidly-aging population, there is a growing need to address mental health in home care services for older adults. Based on a literature review, environmental scan and roundtable discussion, an issues and options discussion paper was written on how best to meet the diverse mental health needs of people reached through home care. The report proposes key targets of change and associated actions, and offers suggestions to build bridges between the home care and mental health care sectors. It will be used to engage a wider network of stakeholders next year in the development of a policy guidance paper.

The MHCC developed the *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada* as a blueprint to build a community-based, integrated system of mental health care and mental health promotion. This year, the MHCC conducted a literature review and environmental scan to identify key policy and program initiatives across Canada that have used components of these *Guidelines*, as well as evaluation results and suggestions on gaps and opportunities for further knowledge mobilization. The review, along with expert input, informed a knowledge translation plan that provided examples of emerging or good practices. The plan will guide the development of knowledge products that encourage uptake of the *Guidelines'* recommendations.

Lesbian Gay Bisexual Transgender Queer Two-Spirit (LGBTQ2+)

The MHCC is building partnerships with LGBTQ2+ networks, communities and organizations to increase the profile of promising initiatives on LGBTQ2+ emerging adult wellness. Over the past year, the MHCC has identified stakeholders, developed an outreach plan and partnered with Wisdom2Action, a national knowledge mobilization initiative with experience in rallying youth. The MHCC supported LGBTQ2+ emerging adult (EA) capacity building and is developing a youth engagement strategy. The MHCC also participated in a stakeholder focus group hosted by the Registered Nurses' Association of Ontario on the future development of LGBTQ2+ best practice guidelines for nurses.

A forum is planned for fall 2018 to generate recommendations about ways to create safer and more inclusive spaces in health care organizations where LGBTQ2+ youth feel welcome and comfortable discussing issues and help to ensure that physical and mental health needs are raised. A checklist to help organizations understand how to implement these recommendations will also be developed.

Employees in Healthcare Services

The By Health for Health Collaborative, led by the MHCC in partnership with HealthCareCAN is comprised of 20 health leaders from across Canada representing over 265,000 workers from physicians to administrative staff. The Collaborative advances workplace mental health practices in healthcare settings through mentoring and knowledge exchange, developing tools and resources, and advancing system transformation (e.g. working with influencers). An online portal for the Collaborative has been launched to better connect members and other stakeholders to enable collective work. The Declaration of Commitment to Psychological Health and Safety in Healthcare was launched in June 2017 and was signed by 39 organizations, representing over 395,000 healthcare workers across Canada. In the coming year, the MHCC will launch a toolkit with practical resources, tools, templates and promising practices to advance workplace practices that support mental health and wellness.

Many family physicians only receive a few minutes of mental health training in medical school and want to receive additional education and support.

Training family physicians helps to provide patients with better services, earlier identification of problems and better support while awaiting a referral to a psychiatrist.

The Healthcare Provider Anti-Stigma Campaign supports the implementation of best practice programs by various provincial and territorial health authorities, professional associations, care providers and educational institutions. These programs include Understanding Stigma, Mental Health Practice Support Program (PSP), on-line continuing medical education programs for family physicians and nurses, etc. Modeled after the evidence-based live workshop program, Understanding Stigma online (understandingstigma.ca) was launched in mid-February 2018. Early evaluation shows it is delivering excellent results at reducing stigma. By the end of March, close to 1,400 people from 17 countries had registered for the course.

Adult Mental Health PSP uses a skills-based approach that has been shown to reduce stigma, increase physician comfort and confidence in treating patients, as well as decrease prescribing medications. Nova Scotia is planning its first train-the-trainer session for its own provincial PSP facilitators so the program can be rolled out easily to family doctors across the province. Eastern Health in Newfoundland is planning to deliver PSP to its first cohort of rural and family physicians beginning in June 2018, with support from MHCC.

> *Aligning with the* Standard *has resulted in some really tangible results that are changing organizational culture.*
>
> **– Caroline Curran,**
> Assistant Deputy Minister,
> Pensions and Benefits, Treasury Board of Canada

Immigrant, Refugee, Ethno-cultural, Racialized (IRER) Populations

The MHCC is working to better understand and serve immigrant, refugee, ethno-cultural and racialized (IRER) populations. Along with partners, the MHCC prepared a briefing note for policy makers related to the Statistics Canada's 2016 census and its implications for IRER mental health. The MHCC is working collaboratively with the Toronto Central Local Health Integration Network and the Sinai Health System to develop content for an IRER toolkit that will focus on socio-demographic data collection in mental health settings. Having this data available is the first step towards being able to analyze differences and improve mental health services provision.

Employees in the Workplace

Following the success of the Workplace Case Study research project, organizations like RCMP Division C and ViaRail have expanded implementation of the *National Standard of Canada for Psychological Health and Safety in the Workplace* (the *Standard*), growing from small pilot sites to their entire organizations nationally. In addition, implementation of the *Standard* has been mandated in all federal workplaces. The MHCC collaborated with the Canadian Mental Health Association (CMHA) – National so the findings from the research project could be embedded in the CMHA's national training and outreach platforms (e.g. Not Myself Today Campaign, Psychological Health and Safety Advisor Training) and disseminated nationally.

The MHCC's two new online training modules – "Being a Mindful Employee: An Orientation to Psychological Health and Safety in the Workplace" as well as the "Assembling the Pieces Toolkit"– were launched March 1, 2018 to promote psychological health and safety in the workplace. They help employees to take action to help themselves and others as well as implement the *Standard*. Both have quickly gained attention across Canada and globally, attracting 529 registrations from 7 countries within a month after their release. Additionally, in partnership with the Conference Board of Canada and human resources associations, the MHCC has delivered 10 workshops on workplace mental health featuring the *Standard* and related tools and resources that reached roughly 500 employers across Canada.

2. People with Lived Experience of Mental Health Problems and Illness

> Stepped care organizes the delivery of health care so that clients receive the least intensive treatment with the greatest likelihood of improvement. *"It means people with mild and moderate problems are treated earlier, before their needs escalate. This substantially reduces or eliminates waitlists and frees up resources for those who require them most,"* explains Dr. Peter Cornish, Director of Student Wellness and Counselling Centre, Memorial University and lead researcher of the MHCC's e-mental health demonstration project.

E-Mental Health

Access to mental health services continues to be a significant barrier to people getting the help they need. E-mental health uses the Internet and related technologies, like phone apps, to enable people to receive care when and where they need it most, regardless of how close they live to their care provider. E-mental health makes sense, since 99 per cent of Canadian households have online access[1]. However, it is not widely used in Canada, despite research that shows the effectiveness and potential of e-mental health interventions.

Stakeholder consultations revealed a need for practical tools and resources to guide service providers and decision-maker about the effective implementation and scaling up of e-mental health programs. A consumer-oriented document called *Mental Health, Technology and You* was disseminated through a social media campaign in late fall of 2017. As well, an e-mental health toolkit will be launched in summer 2018.

1 Source: CRTC, Communications Monitoring Report 2017 https://crtc.gc.ca/eng/publications/reports/policymonitoring/2017/cmr5.htm#s53

The MHCC is collaborating with Memorial University and the Government of Newfoundland and Labrador (NL) to implement and evaluate the integration of e-mental health programs being delivered through a stepped care model of services in 15 community mental health and addiction clinic sites across all four NL health regions. One example involves scaling up an i-CBT (internet cognitive behavioral therapy) program to treat anxiety and depression. The MHCC developed a robust evaluation framework to provide insight into the processes and outcomes of implementing e-mental health, including how it can improve access to services by reducing wait times and overcoming geographic barriers to care.

Full implementation of the e-mental health programs and stepped care model took place in April 2018 across Newfoundland and Labrador. The evaluation report will be completed by March 2019.

Employing People with Mental Health Problems and Illness

Aspiring workers are people who have been overlooked by the workplace or sidelined due to episodic or persistent illness and are struggling to remain in the workplace. The unemployment rate for people living with severe mental illness hovers between 70 and 90 per cent. The MHCC supports the employment of people living with mental health problems and illness by investing in an online site aimed at social enterprises, which builds their capacity to hire individuals living with a mental illness. The MHCC provided support to organizations (using approximately 200 licenses) to freely access over 15 online courses available on the Social Enterprise Institute's (SEI) website, along with coaching sessions to help grow and sustain social enterprises that provide jobs to people living with a mental illness.

The MHCC is launching a national community of practice with supported employment agencies – organizations that help people living with a mental illness to find and sustain meaningful employment – in up to five regions in June 2018. The community of practice will have approximately 25 members and will discuss obstacles, successes and areas of ongoing need.

To build evidence to encourage Canadian employers to recruit and retain individuals living with a mental illness, the MHCC sponsored an Aspiring Workforce research project led by experts who examined the experiences of five case study organizations. Their report included a cost benefit analysis that offered conclusive proof of the financial and workplace advantages of employing these individuals, especially at a time when businesses face serious skill and worker shortages in the labour market. The study found the employer's projected net savings over the five-year span ranged from approximately $56,000 to $204,000 because they accommodated an aspiring worker. The savings resulted from decreased absenteeism/presenteeism, lower turnover and increased productivity. In addition, the worker's projected net income benefit over the five-year span ranged from approximately $31,000 to $67,000.

The next step will entail developing an employer cost-benefit analysis toolkit. The results of the research report and case study project were showcased at several conferences.

Our knowledge translation efforts have included presenting at six workshops and conferences, reaching over 2,000 stakeholders.

> *In my organization we are reviewing the use of seclusion and restraint so this workshop was very timely for me. I will be sharing my learnings with my colleagues.*
>
> **– Seclusion and Restraint Forum Participant**

Seclusion and Restraint

The Mental Health Strategy for Canada identifies the need to reduce or eliminate the harmful practice of seclusion and restraint to manage behaviour in healthcare settings. It is relatively well-known that the use of seclusion and restraint has a significant negative impact on the quality of life and care for individuals living with a mental illness. In addition, exposure to use of seclusion and restraint negatively affects witnesses, including service users and service providers. Seclusion and restraint continues to be used to manage behaviour in mental health care settings amid debate about the dignity and rights of individuals living with a mental illness, consumer and staff safety, practice effectiveness, and models of mental health care.

The MHCC hosted a National Forum on the Use of Seclusion and Restraint in Mental Health Care. The forum highlighted effective international and Canadian strategies for preventing the use of seclusion and restraint. Participants discussed opportunities for scaling-up and expanding implementation of best practices across Canada. The event drew over 80 participants from across Canada and enabled the MHCC to identify key findings and make evidence-based recommendations on strategies to eliminate and/or prevent the use of seclusion and restraint in healthcare. The MHCC is now developing a knowledge translation plan to promote and mobilize the uptake of best practices in healthcare.

3. Other Activities

Knowledge Translation

There is an average gap of 17 years from the time new research is published to its widespread application by organizations. Knowledge translation helps to close this gap and move evidence into practice more quickly. The *SPARK* (Supporting the Promotion of Activated Research and Knowledge) training program builds the capacity of people working in the mental health, substance use and addiction sectors to use knowledge translation techniques to accelerate changes to practice and policy to improve mental health for all Canadians. In 2017-18 we trained 45 *SPARK* participants with a total of over 260 trainees in Canada since 2012. The potential impact of the training extends beyond program participants to their organizations, clients and communities. Qualitative evaluation data demonstrates that *SPARK* participants frequently apply lessons learned from their training to other projects. Trainees have returned to their workplaces and communities to continue building their knowledge translation plans with their stakeholders.

SPARK in Action

Objective: To increase the number of referrals where a treatment team (doctor, nurse, social worker, psychologist, etc.) include the carer's contact information and consent so a Family Peer Support Worker could reach out to the carer.

Lynn used knowledge translation methods learned in *SPARK* to reach out to physicians and nurses in her hospital. These methods included handing out prescription pads for peer support to family members – these prescriptions included AMI (Action on Mental Ilness) Québec contact details and Lynn's direct phone number. She more than doubled referrals from 15 referrals for peer support a month to 35 referrals a month. She continues to use these techniques in her work.

03/4 Engaging Partners to Improve Mental Health Services Provision

To achieve positive mental health outcomes for all the MHCC must collaborate closely with other federal partners, provinces and territories and Canadians at large. Engagement is central to all MHCC activities, including conducting targeted outreach and awareness campaigns. We engage with partners, provinces, territories and Canadians to identify priorities, address data and research gaps and support health research and knowledge exchange initiatives.

Strategic Research Partnerships

Emerging e-mental health initiatives are the product of new strategic research partnerships. For example, a bilingual, plain-language framework to evaluate the quality of mental health apps was co-developed with the Canadian Institute of Health Research's (CIHR) Institute of Gender and Health. A partnership with the Canadian Psychological Association, Canadian Psychiatric Association, Canadian Association of Social Workers and Canadian Counselling and Psychotherapy Association led to the launch of a survey on the use of technology among mental health professionals that generated 700 responses, providing insight into barriers and facilitators for mental health providers. Most respondents are not currently using e-mental health in their practices, although interest is growing, and there is a need for more evidence and leadership. This input will be used to develop strategies to enhance awareness and capacity among mental health providers to use technology-based interventions.

Mental Health Indicators

Having comparable information on the quality of mental health services is needed to identify gaps and opportunities for improvement. The MHCC is advancing the creation of a national scorecard to compare a set of standard provincial and territorial indicators for mental health. Members of the research team presented early project findings to the Mental Health and Addictions Information Collaborative and the MHCC's Provincial/Territorial Advisory Group to elicit strategic advice. The report, *Resources for Developing a Pan-Canadian Performance Measurement Framework for Mental Health and Addiction* includes a map of provincial/territorial policy priorities for mental health and addiction (MHA), features of MHA performance measurement frameworks in Canada, key learnings from provincial/territorial performance measurement framework development processes, and a list of existing and aspirational indicators.

Funding for Psychological Services

Public funding of psychological services would help to overcome a major barrier for a third of people living with mental health problems who have difficulty accessing services. The MHCC is collaborating with federal/provincial/territorial policy makers, mental health professionals and others to explore policy options for publicly fund services. In response to feedback from these partners, a policy options paper was written on implementation considerations for expanding access to psychotherapies in the pan-Canadian context. It provides practical, evidence-based policy guidance at the system level (i.e. provincial and territorial governments) and service planning level (e.g. regional health authorities, hospitals, community mental health centres, professional training programs). The paper reviews lessons learned from reforms in the UK and Australia, and adapts the lessons learned onto the pan-Canadian policy and service-delivery context.

The MHCC has worked closely with the New Brunswick, Ontario, Alberta and British Columbia governments to ensure that the work addresses their needs. The MHCC also hosted several webinars related to this topic to disseminate this knowledge and held a roundtable in Ottawa entitled *Improving Access to Psychotherapy and Psychological Services in Canada: Aligning our Efforts*. This unique event brought together 35 participants representing provincial/territorial policy making bodies, insurers, employers, benefits providers and advisors, service user organizations and researchers. Participants shared perspectives about the roles of publicly-funded psychotherapy programs and employer-based extended health benefits, and discussed how to align efforts to maximize access to psychotherapies and psychological services in Canada. In the coming year, a meeting report will be prepared and knowledge products to encourage uptake will be developed.

> *The continued steady uptake of this document* [The National Standard for Psychological Health and Safety in the Workplace] *speaks volumes to the interest in this area of work and the ongoing support and acceptance the* Standard *is receiving from our stakeholders in the industry.*
>
> **– Jill Collins,**
> Project Manager for Occupational Health and Safety, Canadian Standards Group

Success isn't a given and the MHCC needs to continually work to stay on top of the latest developments in the mental health field, which it does through the Knowledge Activation initiative. It helps teams within the MHCC to develop knowledge exchange methods, tools and technologies. Two regional knowledge exchange meetings were held in Vancouver and Toronto involving a range of collaborators, such as representatives from the Centre for Addiction and Mental Health, the First Nation Health Authority of British Columbia, the University of Guelph and Simon Fraser University. The objective of these meetings was to share innovative ways to translate knowledge to move research into practice.

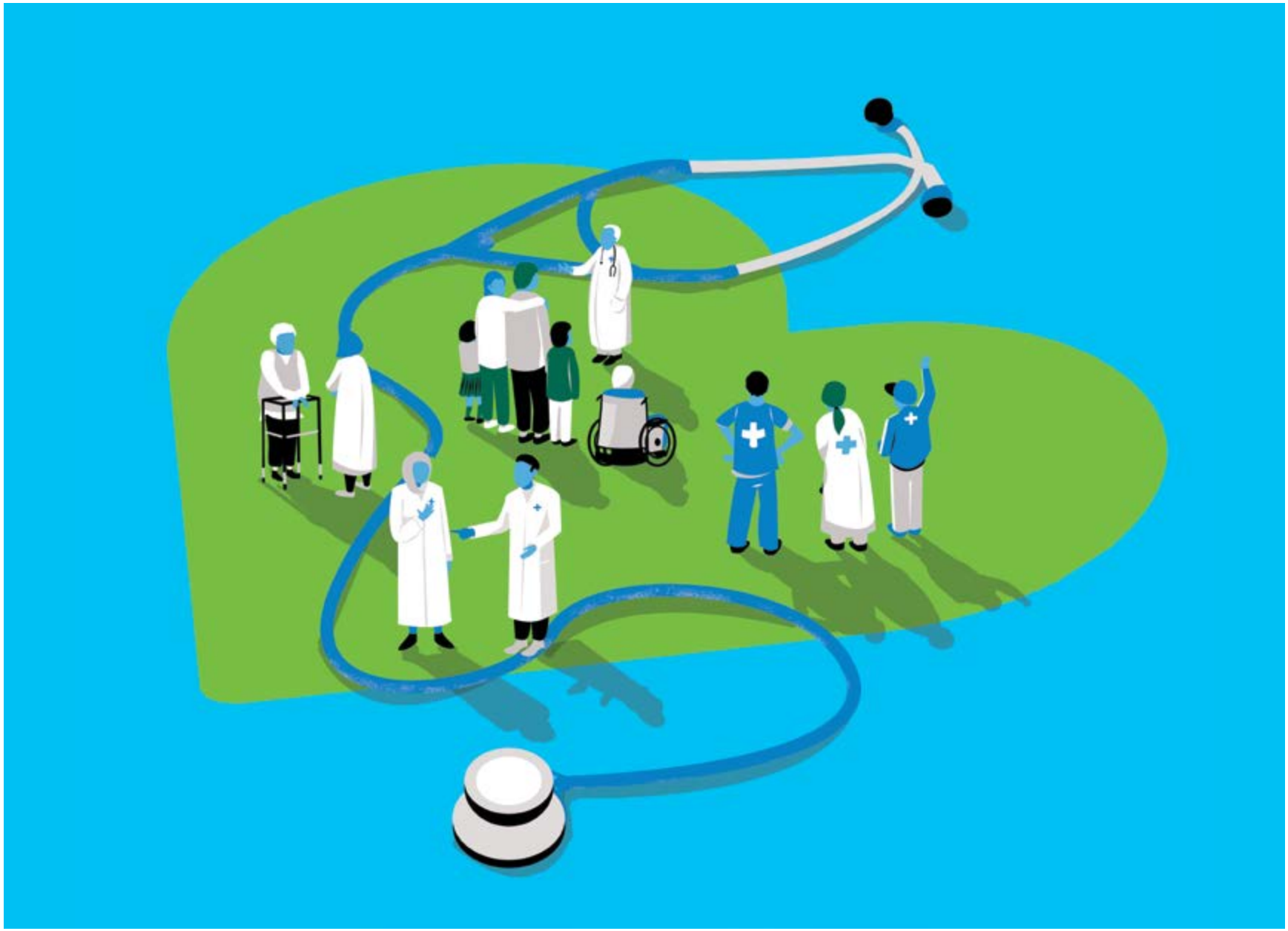
Given the burgeoning field of e-mental health and the MHCC's increased work in the area, we partnered with University of British Columbia to co-host a conference to further bolster knowledge exchange. The conference is geared towards researchers, policy-makers, mental health professionals and people with lived experience and includes topics related to youth mental health and addiction. The e-mental health conference in Vancouver attracted over 175 registrants, a 53% increase in attendance from the previous year.

03/5 Looking Forward

As outlined in this report, the MHCC has achieved measurable progress over the past 12 months. These encouraging results have been bolstered by the August 2017 *Canada Health Accord*, which saw the Government of Canada commit $5 billion over 10 years for mental health and addiction. This has already had, and continues to have, significant implications for access to necessary mental health services for Canadians. Also promising, the federal and provincial governments have concluded a series of bilateral negotiations resulting in an additional $11.5 billion to be transferred to the provinces to advance three priorities with mental health and addiction being one of them.

As positive and inspiring as these developments are, with suicide claiming more than 4,000 Canadians' lives annually and 1.6 million Canadians reporting unmet mental health service needs, much more must be done to ensure mental health and wellness for all.

The MHCC looks forward to taking the next steps in its current work plan over the coming year to help advance this goal. The MHCC is equally enthusiastic to move forward on the next phase of its activities. The Government of Canada has announced that the MHCC will receive $10 million over five years to launch work on the effects of cannabis on mental health. The MHCC will work closely with its many stakeholders and partners as it launches new initiatives to address this important issue next fiscal year.



04

Financial Statements

04/1

Independent Auditors' Report

To the Members of
the Mental Health Commission of Canada

We have audited the accompanying financial statements of the **Mental Health Commission of Canada**, which comprise the statement of financial position as at March 31, 2018, and the statements of operations, changes in net assets and cash flows for the year then ended, and 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. We conducted 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 the auditors' 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, the auditors 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

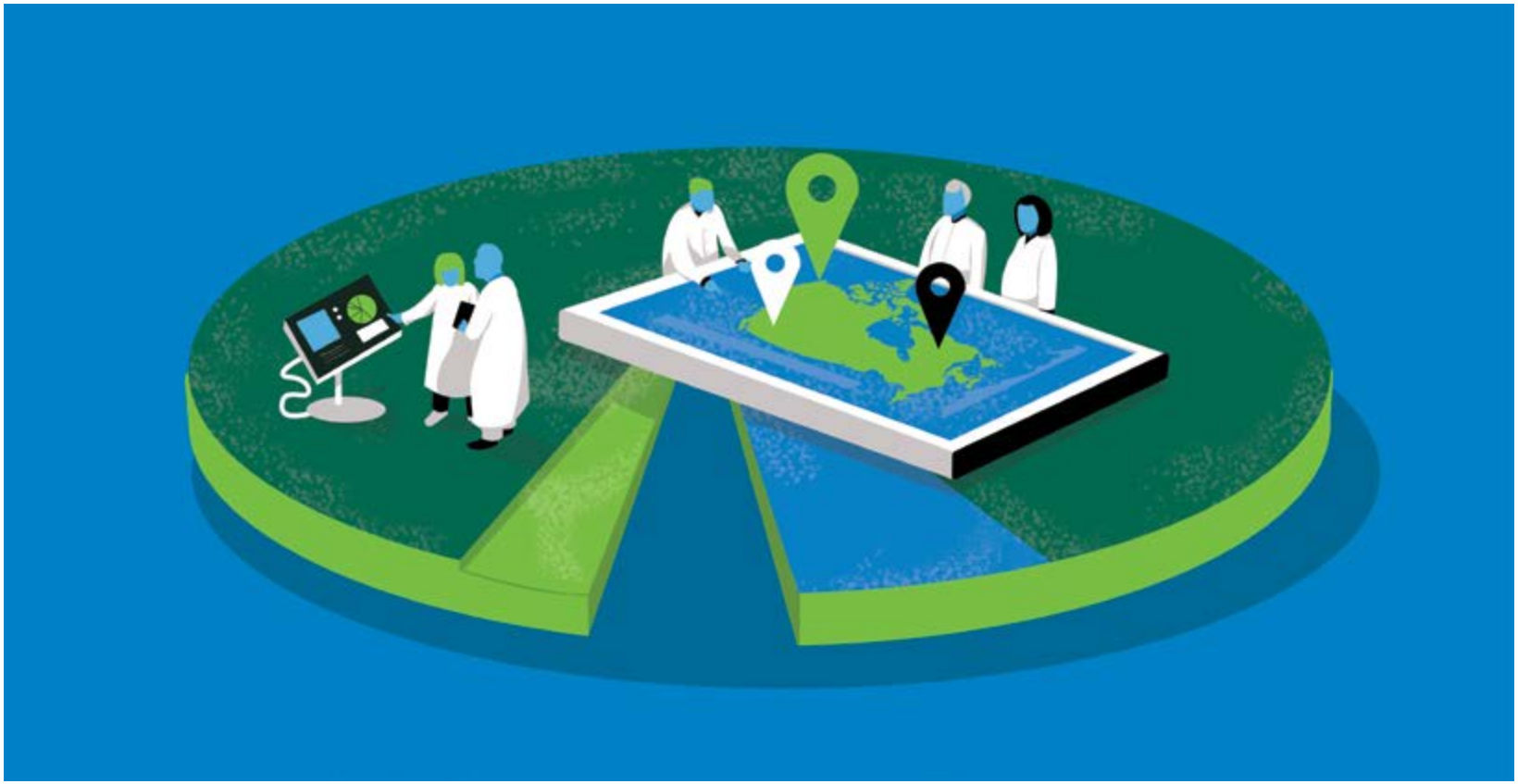
In our opinion, the financial statements present fairly, in all material respects, the financial position of the **Mental Health Commission of Canada** as at March 31, 2018, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Ottawa, Canada
June 26, 2018

Ernst & Young LLP

Chartered Professional Accountants
Licensed Public Accountants

04/2 Audited Financial Statements



Statement of financial position

As at March 31

	2018	2017
	$	$
Assets		
Current		
Cash and cash equivalents	4 119 671	2 160 270
Short-term deposits *[note 3]*	256 675	216 930
Accounts receivable	864 652	2 305 802
GST/HST receivable	186 857	178 061
Deposits and prepaid expenses	512 912	158 265
Inventory	261 633	159 629
Total current assets	6 202 400	5 178 957
Capital assets, net *[note 4]*	1 160 364	1 287 565
	7 362 764	6 466 522
Liabilities and net assets		
Current		
Accounts payable and accrued liabilities	2 052 375	2 998 142
Deferred program fees for MHFA	236 545	157 674
Deferred operating contributions *[note 6]*	1 462 514	80 006
Current portion of deferred tenant lease inducements	131 574	130 903
Total current liabilities	3 883 008	3 366 725
Deferred capital contributions *[note 7]*	360 127	501 080
Deferred tenant lease inducements	1 191 102	1 323 347
Total liabilities	5 434 237	5 191 152
Commitments and indemnification *[notes 8 and 9]*		
Net assets		
MHFA program development reserve fund *[note 5]*	–	331 159
Unrestricted	1 928 527	944 211
Total net assets	1 928 527	1 275 370
	7 362 764	6 466 522

See accompanying notes

On behalf of the Board:

Chair of the Board

Vice-Chair of the Board

Statement of operations

Year ended March 31

	2018	2017
	$	$
Revenue		
Grant income	14 061 014	15 152 649
Mental Health First Aid income	5 692 222	5 394 506
Interest and other income	97 697	140 545
Amortization of deferred capital contributions *[note 7]*	147 635	128 282
	19 998 568	20 815 982
Expenses		
Salaries and benefits	9 275 222	8 963 498
Services	4 236 633	5 360 811
Travel	1 288 806	1 042 567
Rent	683 987	771 693
Meetings and events	913 584	1 421 844
Materials	2 786 925	2 796 128
Amortization of capital assets *[note 4]*	160 254	128 282
	19 345 411	20 484 823
Excess of revenue over expenses for the year	653 157	331 159

See accompanying notes

Statement of changes in net assets

Year ended March 31

	Unrestricted	MHFA program development reserve fund	2018 Total	2017 Total
	$	$	$	$
Net assets, beginning of year	944 211	331 159	1 275 370	944 211
Excess of revenue over expenses	653 157	–	653 157	331 159
Reserve transfers	331 159	(331 159)	–	–
Net assets, end of year	1 928 527	–	1 928 527	1 275 370

See accompanying notes

Statement of cash flows

Year ended March 31

	2018 $	2017 $
Operating activities		
Excess of revenue over expenses for the year	653 157	331 159
Add (deduct) items not affecting cash		
Amortization of deferred capital contributions	(147 635)	(128 282)
Amortization of capital assets	160 254	128 282
Disposal of capital assets	–	116 517
Changes in non-cash working capital balances related to operations		
Decrease (increase) in accounts receivable	1 441 150	(815 215)
Decrease (increase) in GST/HST receivable	(8 796)	165 790
Decrease (increase) in deposits and prepaid expenses	(354 647)	3 602
Increase in inventory	(102 004)	(33 765)
Increase (decrease) in accounts payable and accrued liabilities	(945 767)	1 483 492
Increase in deferred program fees MHFA	78 871	41 174
Increase (decrease) in tenant lease inducements	(131 574)	586 034
Cash provided by operating activities	643 009	1 878 788
Investing activities		
Investment in (proceeds from) short-term deposits, net	(39 745)	186 517
Purchase of capital assets	(111 702)	(550 533)
Leasehold improvement incentive received	–	72 000
Cash used in investing activities	(151 447)	(292 016)
Financing activities		
Grants received related to operations	15 450 205	14 403 542
Grants recognized as revenue related to operations	(13 982 366)	(15 107 045)
Cash provided by (used in) financing activities	1 467 839	(703 503)
Net increase in cash during the year	1 959 401	883 269
Cash and cash equivalents, beginning of year	2 160 270	1 277 001
Cash and cash equivalents, end of year	4 119 671	2 160 270

See accompanying notes

04/3 Notes to financial statements

March 31, 2018

[1] Description of business

The Mental Health Commission of Canada [the MHCC] 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) Support the increased integration of mental health and addiction care systems across Canada.

b) Collaborate with the Public Health Agency of Canada (PHAC) and other partners to better address suicide prevention.

c) Undertake mental wellness and stigma-reduction efforts on at-risk and federal populations such as veterans, Indigenous peoples, and linguistic minority communities.

d) Conduct targeted outreach and awareness mental health and wellness campaigns and address data and research gaps.

The MHCC is registered as a not-for-profit corporation under the Income Tax Act (Canada) and, accordingly, is exempt from income taxes.

On March 31, 2017, the MHCC signed a two-year contribution agreement with the Federal Government for a total of $28,500,000 over two years ending March 31, 2019. The contribution agreement provides for the work of the Commission to continue under four strategic priorities: Substance Abuse/Misuse, Suicide Prevention, Population-based Initiatives, and Engagement.

[2] Significant accounting policies

Financial statement presentation

The financial statements have been prepared in accordance with Canadian accounting standards for not-for-profit organizations in Part III of the *CPA Canada Handbook – Accounting*, "Accounting Standards for Not-for-Profit Organizations." Certain comparative figures have been reclassified to conform to the current year's presentation.

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, 2018.

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.

Cash and cash equivalents

Cash and cash equivalents consist of amounts held on deposit with banks and amounts held in interest-bearing accounts.

Short-term deposits

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

Inventory

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

Capital assets

Capital assets are recorded at cost and are amortized over their estimated useful lives on a straight-line basis using the following estimated useful lives:

IT infrastructure	3 to 5 years
Software	2 to 3 years
Furniture	11 years
Leasehold improvements	over the term of the lease

Financial instruments

Financial instruments are recorded at fair value on initial recognition. 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.

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 the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Estimates include the valuation of accounts receivable and the recoverability and useful lives of capital assets. Consequently, actual results may differ from those estimates.

[3] Short-term deposits

Short-term deposits consist of $256,675 [2017 – $216,930] in Guaranteed Investment Certificates ["GICs"] that mature in less than one year and have an average interest rate of 1.90% [2017 – 1.70%].

[4] Capital assets

Capital assets consist of the following:

	2018			2017
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
IT infrastructure	344,438	112,585	231,853	337,756
Software	150,625	40,172	110,453	40,855
Furniture	232,180	46,945	185,235	205,817
Leasehold improvements	786,424	153,601	632,823	703,137
	1,513,667	353,303	1,160,364	1,287,565

During the year, the Commission recognized $160,254 [2017 – $128,282] in amortization expense.

[5] Mental Health First Aid program development reserve fund

The Mental Health First Aid ["MHFA"] program development reserve fund was created during the fiscal year ended March 31, 2015, is subject to internally imposed restrictions and requires the approval of the Board of Directors for all transactions related to those funds.

At the June 28, 2017 meeting, the Board of Directors approved the elimination of the MHFA program development reserve and that all surplus funds, accumulated and current, be held as unrestricted surplus, to be used to fund development initiatives and/or operating deficits in the future.

[6] Deferred operating contributions

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

	2018	2017
	$	$
Balance, beginning of year	80,006	1,146,905
Grants received – Federal core funding	14,250,000	14,243,480
Grants received – Other grants	527,000	143,880
Grants received – MHFA	673,205	16,000
	15,530,211	15,550,265
Less amounts recognized as revenue		
Federal core funding	(14,058,356)	(14,920,916)
Other grants	(69,897)	(170,129)
MHFA	(80,397)	(16,000)
	(14,208,650)	(15,107,045)
Amounts related to deferred capital contributions	140,953	(363,214)
Balance, end of year	1,462,514	80,006

[7] Deferred capital contributions

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

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

	2018	2017
	$	$
Balance, beginning of year	501,080	1,054,013
Capital contributions	–	363,213
Leasehold improvement inducement received	–	72,000
Leasehold improvement inducement amortized	–	(73,380)
Amount recognized as amortization	(147,635)	(128,282)
Purchase of new capital asset – computer hardware	6,682	–
Leasehold inducements	–	(786,484)
Balance, end of year	360,127	501,080

[8] Commitments

The Commission rents premises under operating leases which expire in 2027. Future minimum annual rental payments to the end of the lease terms are as follows:

	$
2019	288,401
2020	288,401
2021	288,401
2022	292,196
2023	303,580
2024 and thereafter	1,273,139
	2,734,118

[9] 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.

[10] Financial instruments and related risks

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

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 other organizations. 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 amount as at March 31, 2018, $391,175 [2017 – $1,841,637] relates to accrued interest and other receivables.

The Commission is exposed to credit risk on its cash and short-term deposits. The Commission manages this risk by ensuring compliance with the requirements of its Health Canada Funding Agreement. Current investments are held in short-term GICs.

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

Market risk

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

Interest rate risk

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

Liquidity risk

Liquidity risk is the risk that the Commission will be unable to fulfil its obligations as they come due. The Commission manages its liquidity risk by monitoring its operating requirements.

04/4 Salary Range Disclosure

Board of Directors

Compensation for Board of Directors	Annual retainer	Per diem for meetings where minutes are taken	Estimated annual total (based on 6 meeting day/yr)
Chair (for all Board and Committee duties)	Declined	Declined	Declined
Chairs of the Governance and Nominating, Human Resources and Audit and Finance Board Committees	$5,000	$500	$8,000
Non-government members and Government Appointed Private Citizens	–	$500	$3,000
Travel time (when traveling to a meeting where overnight accommodation is required)	–	$250	$750
Participation in Board/ Board Committee/ subcommittee teleconference >60 minutes	–	$250	$750

Compensation for Senior Leadership

Position Title	Annualized base minimum	Annualized base midpoint	Annualized base maximum
President & CEO	$220,000	$245,000	$316,000
Vice Presidents	$144,000	$160,000	$200,000
Directors	$111,600	$124,000	$155,000

Knowing there are others out there with shared experiences, and people on campus who care and want to make things better, has given me the courage to be outspoken about my own struggles with depression and to work to create change on my campus and in the community.

– Clare Hickie,
sixth year psychology student
at the University of Calgary,
a member of the development
committee for The Inquiring Mind

05

Knowledge Products

05 Knowledge Products

The following is a list of knowledge products produced during the year for each of our focus areas.

Title	Type of Knowledge Product
Engagement	
Funding Expanded Access to Psychological Interventions (October 2017)	Webinar
Mental Health Apps: How to Make an Informed Choice	Guide
Options for Improving Access to Counselling, Psychotherapies and Psychological Services for Mental Health Problems and Illnesses	Report
Re-Aiming E-Mental Health: A Rapid Review of Current Research	Report
Roundtable: Exploring Policy Considerations for Expanding Access to Counselling, Psychotherapies, and Psychological Services in Canada	Report
Value and efficacy: Expanding Access to Counselling, Psychotherapies and Psychological Services (September 27, 2017)	Webinar

Population Based Initiatives

A Canadian Framework for Quality Improvement of Collaborative Mental Health Care	Tool
Accompagner le rétablissement, c'est soutenir les forces, la reprise de pouvoir et l'autodétermination	Webinar
Advancing the Evolution: Insights into the State of E-Mental Health Services in Canada	Webinar
Aging, Mental Health and Home Care: Issues and Options Discussion Paper	Report
Assembling the Pieces Toolkit	On-line Training Module
Assessing Knowledge Exchange Needs and Gaps in the Canadian Mental Health, Addiction and Substance Use Sector	Report
Being a Mindful Employee: An Orientation to Psychological Health and Safety in the Workplace	Employee Tool
Building a Business Case for Employers to Actively Recruit and Retain People with Mental Illness (October 2017)	Webinar
Building on a Strong Foundation: A Review of the National Guidelines for a Comprehensive Service System to Support Family Caregivers of Adults with Mental Health Problems and Illnesses	Report
By Health for Health Collaborative Portal	On-line Portal/Tool
Case Studies from Employers, People with Lived Experience and Agencies	Webinar
Collaborative Mental Health Care at Work: Recovery-Oriented Practice and the Patient's Medical Home	Report
Combating Stigma in Healthcare: What Works and Why (June 28, 2017)	Webinar
Consensus Statement on the Mental Health of Emerging Adults	Statement

Cost-Benefit Research Study Findings	Webinar
Critical Incident Stress	Webinar
Declaration of Commitment to Psychological Health and Safety in Healthcare	Statement
Does the Self-Directed Funding Model Work in Mental Health? (June 7, 2017)	Webinar
E-Mental Health Demonstration Project: Mid Term Report	Report
E-Mental Health Demonstration Project Webinar	Webinar
Emerging Adult Knowledge Translation Plan	Report
Emerging Adult Mental Health: Practices of Interest Across Canada	Report
Emerging Adults Seek Change in Mental Health Services	Video Series
Employment and Recovery	Webinar
Evaluation Framework for E-mental Health Applications Survey of Mental Health Professionals	Report
Food for Thought: A Youth Perspective on Recovery-Oriented Practice	Discussion Guide
Food for Thought: A Youth Perspective on Recovery-Oriented Practice (February 2018)	Webinar
Guidelines for Comprehensive Mental Health Services for Older Adults in Canada	Guidelines
Improving Connections and Learning through Knowledge Activation, 2017-2018	Report
Introduction to the Guidelines for Recovery-Oriented Practice (French only) (April 6, 2017)	Webinar
Knowledge Exchange Gaps and Needs in the Canadian Sectors of Mental Health Substance Use and Addiction	Report

La base de l'approche rétablissement : Promouvoir une culture et un langage empreints d'espoir (28 septembre 2017)	Webinar
Le rétablissement passe par la transformation des services, de la structure, de la culture et des systèmes	Webinar
Mental Health in the Workplace: The Duty and Benefits of Accommodating Employees with Disabilities	Webinar
Mental Health Technology and You (Consumer-facing companion product to the toolkit)	Tool
Moving Forward Together: A Multi-Stakeholder Dialogue on Meeting the Needs of Family Caregivers of People Living with Mental Health and Addiction Problems or Illnesses	Report
National Forum on the Use of Seclusion and Restraint in Mental Health Care Summary Report of Key Findings	Report
Recovery-oriented Practice and Immigrant and Refugee Populations (April 20, 2017)	Webinar
Seniors Home Care and Seniors Mental Health Activities: Literature Review and Environmental Scan	Report
Seniors Home Care and Seniors Mental Health Activities: Roundtable Proceedings	Report
Social Enterprises: An Innovative Approach to Creating Employment Opportunities for People Living with Mental Illness (May 31, 2017)	Webinar
Social Procurement/Social Business/Enterprises	Webinar
SPARK 2016 Wrap-up (September 27, 2017)	Webinar
SPARK 2017 Mid-Year Evaluation Report	Report
SPARK 2018 Winter Evaluation Report	Report
Stakeholder E-Mental Health Collaborative Meeting Report	Report

Stakeholder Engagement (December 2017)	Webinar
Stigma in Healthcare Sector	Webinar
Stress, the Brain and Mental Health Hygiene (April 26, 2017)	Webinar
Substance Use Workplace Policies	Webinar
Sustaining Implementation of the Workplace Standard: One-year Follow-up Study with Case Study Research Project Participants	Report
The Inquiring Mind Train-the-trainer and participant packages: facilitator manuals	Training Package
The Workplace and Suicide Prevention	Webinar
Travailler ensemble, Premières Nations, Inuit, Métis	Webinar
Une diversité d'approches pour répondre aux besoins diversifiés de toute personne vivant au Canada	Webinar
Viser la pleine citoyenneté pour tous : parce que le rétablissement se produit dans le contexte de la vie	Webinar
Why Buying Social is Good for Business: Leverage Your Purchasing to Create Greater Value (January 2018)	Webinar
Working to Better Support Families and Other Unpaid Caregivers in Mental Health and Addiction	Report
Working towards Recovery: Lessons on Employment Supports from CMHA Ottawa (August 30, 2017)	Webinar
Youth Council Facebook Live Broadcast	Webinar
Youth Council Whiteboard Video	Video

Substance Use and Addiction

Life in Recovery: Lessons from the Canadian Centre on Substance Use and Addiction (CCSA) (October 2017)	Webinar
Mental Health and Addictions Information Collaborative Meeting	Report

Suicide Prevention

Suicide Awareness and Prevention Suicide Awareness and Prevention for Supervisors (adapted for First Responder Francophone populations)	On-line Training Modules
Bullying and Suicide	Fact Sheet
Implementation of Good Practices in Suicide Prevention in Quebec: An Innovative Project (French only) (November 2017) (Implantation des bonnes pratiques en prévention du suicide au Québec : un projet novateur)	Webinar
Injury Prevention	Fact Sheet
Myths and Facts: Suicide Prevention in the Workplace (November 2017)	Webinar
Suicide Portrayal in the Canadian Media: Examining Newspaper Coverage of the Popular Netflix Series “13 Reasons Why”	Research Paper
Suicide: Facing the Difficult Topic Together – Empowering Nurses, Instilling Hope in Patients	On-line Training Module
Suicide: Facing the Difficult Topic Together – Empowering Physicians, Instilling Hope in Patients	On-line Training Module
Toolkit for People Who Have Been Impacted by Suicide Attempt	Toolkit
Toolkit for People Who Have Been Impacted by Suicide Loss	Toolkit
Trauma-Informed Care and Suicide	Fact Sheet

06

Partnerships

We are delighted to partner with the MHCC to adapt and host their successful classroom workshop as a free, online course – making it even more accessible to professionals across the country. We are making progress on reducing the stigma of mental illness. As healthcare providers, we must continue to challenge our own attitudes and co-create strategies with our patients to address stigma.

– Dr. Ivan Silver,
Vice President of Education,
Centre on Addiction and Mental Health

06 Partnerships

The MHCC partners with a wide array of organizations in the mental health, non-mental health, private and public sectors and would be unable to do its work without them. These partners provide expertise, connections to the community, and facilitate engagement and the spread of knowledge.

Below is a list of our partners for each project in the work plan:

Caregivers Guidelines – Peer Support Canada and the Department of Psychology, Wilfrid Laurier University

Community of Practice – Centre for Addiction and Mental Health, Royal Ottawa Hospital

Disability Income Support Forum – McMaster University

E-Mental Health Knowledge Exchange Conference – University of British Columbia

E-Mental Health Strategic Partnerships Research Support – Canadian Institute of Health Research (CIHR)-Institute of Gender and Health, Canadian Psychological Association, Canadian Psychiatric Association, Canadian Association of Social Workers, Canadian Counselling and Psychotherapy Association

E-Mental Health Toolkit – MHCC's Youth Council, Advisory Council, Hallway Group, Stella's Place and East Metro Youth Services

Expanding Access to Psychological Services – Centre for Addiction and Mental Health (CAMH) Provincial Systems Support Program, First Nations Health Authority

Factsheets – Centre for Suicide Prevention (CSP)

First Responder Knowledge Exchange – Association of Public Safety Communication Officers, Canadian Association of Chiefs of Police, Canadian Police Knowledge Network, Council of Canadian Fire Marshalls and Fire Commissioners, International Association of Firefighters-Canadian Chapter, Ontario Public Services Health and Safety Association, Paramedic Association of Canada, Paramedic Chiefs of Canada, Public Safety Canada, Tema Conter Memorial Trust, University of Regina Centre for Justice and Safety

Health Collaborative – HealthCare*CAN*

Healthcare Provider Anti-Stigma Campaign – CAMH, Eastern Health in Newfoundland and Labrador

ITK National Suicide Prevention Strategy – Inuit Tapiirit Kanatami (ITK)

Knowledge Activation – CAMH, Provincial Systems Support Program

Knowledge Exchange – Association québécoise de prévention du suicide (AQPS), Canadian Mental Health Association (CMHA), Canadian Association of Suicide Prevention (CASP)

Knowledge Exchange (KE) Collaborative – Canadian Centre on Substance Use and Addiction (CCSA)

Magnet Demonstration Project – Magnet

Mental Health and Addictions Information Collaborative – Terms of reference exists for the following members: Canadian Institute for Health Information (CIHI), Canadian Institute for Health Research (CIHR), Health Canada, CCSA, Public Health Agency of Canada (PHAC), Statistics Canada

National Collaborative on Suicide Prevention – CASP, PHAC, CCSA, CIHR, AQPS, CMHA, Arthur Sommer Rotenberg Chair in Suicide Prevention, Assembly of First Nations, Canadian Coalition for Seniors Mental Health, Canadian Mental Health Association of British Columbia, Canadian Psychiatric Association, Canadian Psychological Association, Centre for Suicide Prevention, First Nations and Inuit Health Branch, Indigenous Services Canada, Inuit Tapiriit Kanatami, Mood Disorders Association of Canada

National Mental Health Scorecard – CIHI

National Suicide Prevention Research Demonstration Project – Government of Newfoundland and Labrador, Eastern Health Region, Government of New Brunswick, Vitalité Health

Ongoing Policy and Research Work – CCSA

Online Modules - First Responders – Canadian Police Knowledge Network

Online Modules - Healthcare Workers – Federation of Medical Women of Canada; CASP

Online Social Enterprise Ecosystem – Economic and Social Development Canada, Social Enterprise Institute, Buy Social Canada, The Canadian Community Economic Development Network, Chantier De L'Économie Sociale, Social Value Lab, McConnell Foundation, Social Enterprise Council of Canada, Social Enterprise Institute, Causeway Group

Opening Minds Stigma Reduction Research for Opioid Addictions – Québec City Police, Addictions Foundation of Manitoba, Canadian Research Initiative in Substance Misuse (CRISM), Fraser Health Authority

Paramedic Standard – Paramedics Association Canada, Canadian Standards Association, Paramedics Chiefs of Canada

Partnerships – CMHA, CASP, Canadian Foundation for Healthcare Improvement (CFHI), ITK, Métis National Council (MNC), CSP

Prevention and Promotion – CASP, AQPS, Wisdom2Action

Primary Care/Collaborative Care – St. Michael's Hospital

Primary Care/Collaborative Care – Terms of reference exist for the following members: CIHI, CIHR, Health Canada, CCSA, PHAC, Statistics Canada

Recovery Accreditation – Accreditation Canada, Canadian Centre for Accreditation, Commission on Accreditation of Rehabilitation Facilities (CARF) Canada

Recovery and Youth – Youth Advisory Council, Ontario Shores

Recovery French Webinar Series – l'Association québécoise pour la réadaptation (AQRP)

Recovery Knowledge Exchange – Collaborative Working Group on Shared Mental Health Care, Waypoint, Psychosocial Rehabilitation (PSR) Canada, among others

Recovery Regional Events – Range of local and provincial stakeholders

Recovery Webinar Series – PSR and AQRP

Research Priority Setting – Public Health Agency of Canada

Seclusion and Restraint – Trillium Health Partners, Ontario Shores, Schizophrenia Society of Canada, Canadian Coalition of Seniors Mental Health

***SPARK* (Supporting the Promotion of Activated Research and Knowledge)** – CAMH, CCSA, CMHA, University Health Network, City of Vancouver

Stakeholder E-Mental Health Collaborative Meetings – Canadian Institutes of Health Research's Institute of Neurosciences, Mental Health and Addiction (INMHA)

Stakeholder E-Mental Health Collaborative Meetings – Terms of reference for the Collaborative exist for the following members: Royal Ottawa/University of Ottawa, Université du Québec en Outaouais, University of Calgary, Université de Montréal, UBC, University of Regina, Strongest Families Institute, Kids Help Phone, Canadian Institute of Natural and Integrative Medicine, Canadian Mental Health Association, CAMH (University Health Network), Mental Health and Addictions, Government of Newfoundland and Labrador, First Nations and Inuit Health, Health Canada, CCSA, Canadian Psychiatric Association, Canadian Psychological Association, Canada Health Infoway, Canadian Foundation for Healthcare Improvement, Thunderbird Partnership Foundation

Survivors of Suicide Attempt Toolkit – CASP, Arthur Sommer Rotenberg Chair in Suicide Prevention, Centre for Suicide Prevention

Survivors of Suicide Loss Toolkit – CASP, Arthur Sommer Rotenberg Chair in Suicide Prevention, Centre for Suicide Prevention

The Inquiring Mind – University of Calgary, Mount Royal University, University of Lethbridge, MacEwan University, Memorial University, Dalhousie University, Dalhousie Medical School, Nova Scotia Community College

Workplace Case Study Promotion – Ottawa Public Health, Conference Board of Canada, Electricity HR Canada, Human Resources Professional Association, Workplace Safety and Prevention Services, Canadian Mental Health Association

Workplace Knowledge Exchange – CSA, Bureau de normalisation du Québec, Canadian Centre for Occupational Health and Safety, Lundbeck Canada, Conference Board of Canada, Morneau Shepell, SunLife Financial, HealthCareCAN, Human Resources Professional Associations, Mindful Employer

Members of the Board of Directors

The Hon. Michael H. Wilson
(Board Chair) (current)

John G. Abbott
(current)

Teresa (Tera) Beaulieu

Charles J. Bruce
(current)

Kim Calsaferri
(current)

Uppala Chandrasekera
(current)

Manon Charbonneau
(current)

Mike Dalton
(current)

Christine Donoghue
(current)

Cheryl Fraser
(current)

Arlene Hache
(current)

Mark Henick

Anne-Marie Hourigan
(current)

Richard Jock
(current)

Marc-André LeBlanc
(current)

Alisa Praamsma
(current)

Peter Ralph

Executive Leadership Team

Louise Bradley
President and
Chief Executive Officer

Ed Mantler
Vice President,
Programs and Priorities

Michel Rodrigue
Vice-President,
Organizational Performance
and Public Affairs

Robert Thomas
Vice President,
Corporate Services and
Chief Financial Officer

Mental Health Commission of Canada

Suite 1210, 350 Albert Street
Ottawa, ON K1R 1A4

Tel: 613.683.3755
Fax: 613.798.2989

info@mentalhealthcommission.ca
www.mentalhealthcommission.ca

@MHCC_ /theMHCC /1MHCC @theMHCC
/Mental Health Commission of Canada