HIDDEN HEROES

Annual Report 2019–2020

Mental Health Commission of Canada

Commission de la santé mentale du Canada

Hidden heroes – Annual Report 2019–2020
Mental Health Commission of Canada

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Health Canada Santé Canada

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Join us on our journey

As I sit down to write this, our world reminds me of a snow globe that's been shaken and hasn't yet been put to rights. The fallout from COVID-19 isn't well understood, but we know that next year will look very different from the last one.

2019–20 was a foundational year at the Mental Health Commission of Canada (MHCC), and I believe the year ahead will be one of exponential growth. For my entire career, I have advocated for the parity of mental health care, pulling at heartstrings and tugging at purse strings. The MHCC has built a case for investment based on the bottom line, and a call to action rooted in parity's moral imperative.

I've worked on the front lines of mental health, as a nurse and clinical therapist, and I've walked the winding road to recovery from mental illness. With every mile I've met others along the way whose conviction, that we must advocate for parity, mirrors my own. From peer supporters and housing advocates to people with lived experience of substance use and survivors of childhood trauma, we are bound by the belief that to ignore the wellness of our minds is to imperil our health. Period.

Until we stop making excuses and start opening our hearts, we'll all remain travellers on a journey fraught with barriers, unable to reach the shelter offered by universally accessible supports and services.

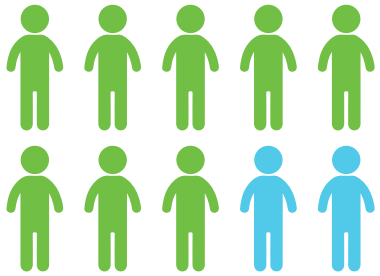
Make no mistake. Not one of us can be sure our lives won't diverge onto an unexpected path.

Some of us may need a single session with a counsellor to get back on track. Others may require intensive, long-term supports. But if we're lucky, we stumble upon hidden heroes – peer supporters, social workers, psychotherapists, nurses, or physicians – who see our value and believe in our recovery.

More and more, travellers have joined us in the weeks since the onset of COVID-19. A physical pandemic has highlighted a crying need as vast and diverse as the nation we call home. In this brief window of time – a veritable blink of an eye in policy development – an onslaught of innovations and interventions have risen from a collective will mobilized by the eye-opening realization that protecting our bodies from harm is only half the battle.

We are closer to the cusp of parity than we've ever been.

The MHCC has been working toward this moment for more than ten years, while some of our stakeholder partners have been toiling in the annals of mental health for ten decades. In January, a Nanos poll conducted for the MHCC reaffirmed that more than eight in 10 people in Canada believe physical health care and mental health care are equally important.



8 IN 10 PEOPLE in Canada believe **physical health care** and **mental health care** are equally important

It's fitting, then, that our 2019–20 annual report highlights achievements that are serving as beacons of innovation across jurisdictions, which are searching to scale up a rapid response to a need that has now been boldly named and can no longer be ignored.

Some of us may need a single session with a counsellor to get back on track. Others may require intensive, long-term supports. But if we're lucky, we stumble upon hidden heroes – peer supporters, social workers, psychotherapists, nurses, or physicians – who see our value and believe in our recovery.

In this report, I am proud to introduce four projects that illustrate the kinds of results that are born from collaboration, innovation, and the compassionate perspective of lived experience:

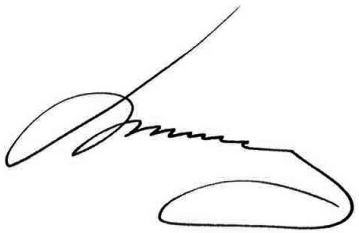
- Roots of Hope, our strengths-based community suicide prevention program, has grown to encompass eight communities, with many others eager to sign on in phase two.
- Stepped Care 2.0, an e-mental health project championed by the MHCC that has reduced wait times in Newfoundland and Labrador by 68 per cent, and served as the framework for the federal government's Wellness Together Canada portal.
- The reality of how stigma colours the perspective of health-care providers on the front lines of the opioid crisis was uncovered through dozens of key informant interviews from both sides of the care divide.
- And finally, our lived experience forums, centred on better understanding the harms and potential benefits of cannabis and mental health, which remind us that academic research is just one avenue for collecting knowledge that allows us to meet the needs of those we serve.

555
PARTNERSHIPS

As we stride boldly into a new context – thrust from our comfort zones yet required to think creatively and connect virtually – we've also been given an extraordinary opportunity to set aside the status quo in favour of something better.

2019–20 has proven that the MHCC has what it takes to reimagine a future defined by improved access to mental health supports, greater input by experts with lived experience, strengthened community-based services, and enhanced supports for health-care providers. This work has been made possible through the dedicated efforts of our staff, who rise to meet challenges with conviction, compassion, and collaboration.

Together, we are committed to building a society that meets us where we are, and offers us the help we need.



Louise Bradley
MHCC President and CEO

Count me in

I'm a numbers guy. I understand their scope. I get their nuanced meaning. Tell me that 500,000 people have been trained in Mental Health First Aid – a milestone the Mental Health Commission of Canada (MHCC) reached this year – and I get excited. I know just how vast that number is, especially compared to 10 years ago, when the program was born on the back of a napkin around a kitchen table.

Tell me that mental illness costs the economy $50 billion annually, and while no longer staggered by the sheer amount, I'm confounded that it isn't motivation enough to mobilize a rapid response team, roll up our sleeves, and get to work.

When I hear that 500,000 people miss work every week due to a mental health problem, my brain starts crunching the lost productivity, the missed opportunities, and the human toll.

Tell me that since the onset of COVID-19, 40 per cent of the people in Canada are saying their mental health is worse, or somewhat worse, and my mind whirrs with the implications, both economic and emotional.

But not everyone operates like I do. Numbers ring hollow for some. They're too big, or too impersonal. While last year we told the story of the MHCC's achievements by the numbers (which spoke to my accountant's heart), this year we're taking a different approach.

Rather than tell you what we've done, we've decided to introduce you to a few of the people who are doing the work. We want to tell you our story through the eyes of four hidden heroes.

Laying the groundwork for policy change may not sound exciting until you hear the passion in Dr. Stephanie Knaak's voice when she speaks about the compassion fatigue and burnout plaguing our health-care providers, and the resulting stigma that's hindering care for people living with opioid addiction.

If you think research is a dry business, take a listen to Dr. Brian Mishara, the principal investigator for Roots of Hope, articulating the importance of culturally appropriate care, with a focus on how communities must dictate what they need, lest the mistakes following the genocide in Rwanda be repeated.

Similarly, one conversation with Stepped Care 2.0's Dr. Peter Cornish – who likens accessing psychiatric care in this country to waiting for an expensive backhoe when a plain old shovel might do – may convince you, as it did me, that overhauling our system doesn't have to be complicated to be effective.

"Of course clinicians and researchers are crucial to our efforts. But Susan Boyce reminds us that it's the voices of lived experience that give us the insights we need to make sure the programs we design and policy recommendations we make meet the needs of those we serve."

In the context of COVID-19, the curtain has been pulled back on many hidden heroes. We have a renewed appreciation for health-care providers, personal support workers, delivery people, and grocery store clerks. But even before this paradigm shift, the MHCC was busy putting together profiles of behind-the-scenes superstars whose efforts are quietly reshaping mental health care in this country.

Numbers are important. They can make you sit up and take notice. They can impress the heck out of you. They're hard to refute.

But even I know they can't tell the whole story.

Our numbers are impressive, but our people are our heart. In particular, I would like to acknowledge the tremendous contribution of our board directors. It's through their creativity, empathy, and co-operative spirit that ideas are born. Numbers are important, but ideas change the world.

I hope you'll join us as we take a journey with our community of change-makers, whose leadership of thought, and deed, is creating a better tomorrow.

Chuck Bruce
MHCC Board Chair

Dear readers,

At the Mental Health Commission of Canada, we believe there is a hidden hero in all of us.

To people with lived experience, who are walking the long and winding journey to recovery, there are days when it is heroic to simply put one foot in front of the other.

To our partners in the sector, who have corrected us when we have made mistakes, who have shared wisdom without being asked, who have freely lent us expertise, your generosity of spirit is a heroism to which we aspire.

To our champions of mental health in workplaces across the country, in the halls of Parliament, in high schools and communities, you know who you are. Your acts of heroism, big and small, inspire us every day.

To the front-line health-care providers and first responders, who are working to beat back stigma from all sides, seeking help for yourself is as heroic as the daily care you provide.

To the half a million people in this country who have trained in Mental Health First Aid, you've equipped yourself with a superpower that is nothing short of life-saving. To the hundreds of thousands of high school students who have participated in HEADSTRONG summits across this country, your heroic journey is only just beginning. We can't wait to see how you're going to change the world.

To our Youth and Advisory Council members and our Hallway Group, your willingness to challenge us and demand the best of us is the kind of heroism we need more of – in every facet of society.

Finally, if you have reached out a hand to someone struggling, or if you have reached out to ask for help, you too are a hero in our eyes.

Sincerely,

your friends at the MHCC

01

Peter Cornish: Making wait times disappear

In his new book, psychologist Peter Cornish describes the "aha moment" he had as he was considering the U.K.'s National Health Service stepped care model.

"I was thinking about whether stepped care for mental health could provide the structure needed for low-intensity self-help treatments in our rural and remote regions," he said. "Then something clicked. Here I was, director of a university counselling centre that was struggling to meet demand. Could stepped care help? I quickly sketched out the first of many plans that eventually led to our nine-step model."

Stepped care 2.0 is a system of delivering mental health care using the most effective, least resource-intensive treatment first, only "stepping up" to intensive or specialist services if required. It provides rapid, same-day, flexible access to wellness and mental health resources, including e-mental health (EMH) interventions like telehealth and smartphone apps.

"When someone says they're stressed or feeling down," said Cornish, "society tells us to 'Go get in line, see a psychologist or a psychiatrist.' But you may have to wait six months or more, and not everyone needs that level of expertise. As one focus group member put it, 'It's like waiting for a backhoe when all you may need is a shovel.'"

"What Peter has done is nothing short of reimagining a better, more responsive, more efficient system of care," said Nicholas Watters, director of Access to Quality Mental Health Services at the Mental Health Commission of Canada (MHCC). "He's rewriting the playbook, and we're only too happy to be his biggest champion."

"When someone says they're stressed or feeling down, society tells us to 'Go get in line, see a psychologist or a psychiatrist.' But you may have to wait six months or more, and not everyone needs that level of expertise. It's like waiting for a backhoe when all you may need is a shovel."

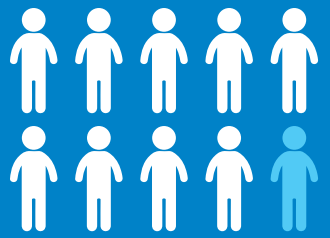
Cornish says his model is geared toward an individual's treatment preferences and is more flexible than traditional stepped care, where people must try one treatment option before moving on to the next.

"If somebody wants help, they should be able to get it the same day," he says. "When they're asking for help, the worst thing we can do is tell them to wait."

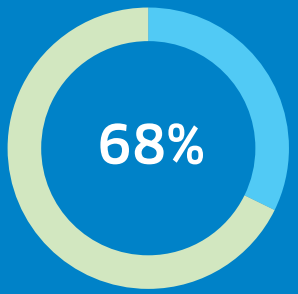
In September 2017, the 18-month stepped care 2.0 e-mental health demonstration project was launched. The project set out to identify ways to improve access to mental health services by implementing and evaluating Stepped Care 2.0. It was made possible through a partnership between the MHCC, Memorial University of Newfoundland (MUN), the provincial government, its four regional health authorities, and CHANNAL (Consumers' Health Awareness Network Newfoundland and Labrador). Cornish co-led a multi-stakeholder team for the project, conducted over 17 sites across the province (15 community-based locations and two primary health-care clinics).

"If somebody wants help, they should be able to get it the same day. When they're asking for help, the worst thing we can do is tell them to wait."

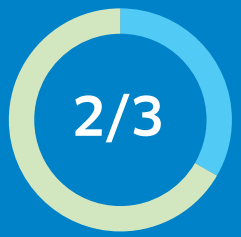
As the project's final report showed, Stepped Care 2.0, in conjunction with the implementation of the province's Towards Recovery Action Plan, helped reduce wait times by 68 per cent, with some communities having zero wait times. More than



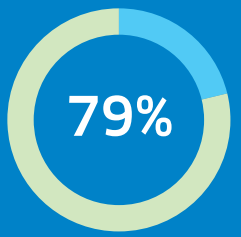
9 OUT OF 10
say **increasing funding** to improve access to mental health care professionals should be a high/medium priority



reduced wait times based on help from **Stepped Care 2.0**, in conjunction with implementation of the province's **Towards Recovery Action Plan**



of the participants rated the **EMH tools good or excellent**



say the **tools** met at least some of their needs

two-thirds of the participants rated the EMH tools good or excellent, and 79 per cent said the tools met at least some of their needs. Care providers who received stepped care training also reported much greater comfort with EMH tools.

This success underscores the value of incorporating technology into primary mental health care.

"What I brought to the table was the container," said Cornish, "the structure for all the amazing things already going on in Newfoundland and Labrador. Through the demonstration project, I was able to look around to see innovations that could fit into this model.

"Newfoundland was already training staff in single session therapy and developing EMH, but they were also developing the recovery model – theory and practices based on more respect for users of mental health services. In addition, the province used a trained peer-support network called CHANNAL, where people with lived experience provide self-help mental health services. This network is part of the health-care system and is unique in Canada.

"But without the MHCC's support, I would not have discovered several things that are now core components of Stepped Care 2.0. The MHCC brings innovators together and helps them negotiate relationships. I had some ideas people thought were valuable, but when the MHCC put me in a room with other people and their ideas, it meant I could populate the framework in a much richer way. Without that relationship, none of this would have happened."

Following the project, the team secured $1.2 million from the Canadian Institutes of Health Research to develop a technology platform and evaluate its potential for improving mental health care and access in Newfoundland and Labrador and Nova Scotia. The model also contributed to the federal government's Wellness Together Canada portal, a joint COVID-19 mental health and substance use project launched by Health Canada.

"The MHCC brings innovators together and helps them negotiate relationships. I had some ideas people thought were valuable, but when the MHCC put me in a room with other people and their ideas, it meant I could populate the framework in a much richer way. Without that relationship, none of this would have happened."

"I'm so proud the MHCC was able to give Peter a platform to help reach even more people in Canada," said Watters. "With his vision, expertise, and proven methods, a lot more people are going to get the help they need. Peter may not be a hidden hero much longer."

02

Brian Mishara: Bringing hope to life

"Suicide is a hidden crisis in this country. If we want to reduce rates that have remained stagnant for ten years, we've got to bring to bear the best and brightest in service of prevention."

– Louise Bradley, MHCC President and CEO

Included in this group is professor Brian Mishara, who was hand-picked as the principal investigator of Roots of Hope, the MHCC's signature suicide prevention project, launched in September 2019.

"We are so lucky Dr. Mishara accepted this challenge," said Karla Thorpe, the MHCC's director of Promotion and Prevention. "Think of his role like the conductor of an orchestra. People can play beautiful music on their own, but it takes a visionary to bring the players together harmoniously."

While many projects focus on what works, Roots of Hope intentionally addresses contextual issues and challenges that are specific to each community – as well as how the community rises to meet them.

In this case, the eight Roots of Hope communities are the "players" and Mishara is the "conductor" overseeing their progress as they combine local strengths with evidence-based measures to reduce suicides.

With a combined population of 1.8 million, the program's participating communities include rural, urban, francophone, northern, and Indigenous populations. This diversity allows the MHCC to learn what is effective for reducing suicide in a range of settings and groups across Canada.

In sketching out an overview of the project, Mishara is especially proud of the integral part of research in its construction. While many projects focus on what works, he explained, Roots of Hope intentionally addresses contextual issues and challenges that are specific to each community – as well as how the community rises to meet them.

His example is as poignant as it is powerful. When psychologists descended on Rwanda following the country's horrific genocide, seeking to provide trauma-informed care to people who experienced unfathomable atrocities, their efforts were having precisely the opposite effect to what they intended – even though evidence based. The reason was astonishingly simple had anyone listened. The Rwandan people said they needed three things to heal: their

8 IN 10 PEOPLE
say that **suicide prevention programs** should be a **high/medium priority**

family around them, the open air and sunshine, and the opportunity to share happy memories. Instead, they were being separated from loved ones, brought to a darkened room, and asked to relive their trauma.

Roots of Hope, in its wisdom, doesn't seek to presume the appropriate solutions but rather relies on the strengths and specifics of local communities to fill in the blanks around its five pillars of prevention.

Ever humble, Mishara, whose PhD dissertation focused on suicide and self-injurious behaviour, is quick to credit the people on the ground. "The local researchers are responsible for assessing each community. My role is to try to see that we are all doing this in the same way."

And no one is better placed to tackle a project as important as Roots of Hope. The depth and breadth of Mishara's experience includes his early research in support of suicide helplines. From there, his long list of accomplishments and the impact he's had in the field of suicide prevention, both nationally and internationally, cannot be overstated.

"His heroics are quiet. And they are unsung. But they are no less worthy of celebration."

Mishara is one of the founders of Suicide Action Montréal. He joined with colleagues to start the Association québécoise de prévention du suicide. He then served as president of the Canadian Association for Suicide Prevention and (later) as president of the International Association for Suicide Prevention, which is affiliated with the World Health Organization.

"Work like Dr. Mishara's doesn't often make the frontpage of the newspapers," said Bradley. "And that is precisely why we want to showcase it. Evaluating projects by collecting data in a uniform way may not sound heroic. But he is laying a foundation that has the capacity to save thousands of lives."

As Thorpe sees it, "His heroics are quiet. And they are unsung. But they are no less worthy of celebration."

03

Stephanie Knaak: Fighting an invisible enemy

When Stephanie Knaak talks about her new research, you can hear the urgency in her voice. Knaak is the MHCC's co-lead researcher on a study looking at how stigma affects first responders' ability to provide care amid Canada's opioid overdose crisis.

Until recently, her research was squarely focused on combating stigma related to mental illness, a hidden enemy that prevents too many people from stepping forward and seeking help. Knaak's interest in the topic is beyond professional. She lost her best friend to suicide in 2012. "I guess you could say my chosen career became a vocation overnight."

Louise Bradley, MHCC president and CEO, is Knaak's biggest fan. "Stephanie is as humble as she is brilliant. She's got the keen mind of a researcher, but it's the heart she brings to her work that truly sets her apart."

Knaak is now turning her attention to what may be her biggest challenge yet.

In 2017, Health Canada asked the MHCC to adapt some of its anti-stigma programs to the problem of opioid use.

"We can do that," Knaak thought, "but this stigma is going to look and feel different. It involves political issues around harm reduction, general perceptions of people who use opioids, attitudes toward homelessness – and the list goes on."

She then asked the natural question: "Can we do more research?"

That was the beginning of an 18-month project funded by Health Canada.

"I was tagged to lead that research," said Knaak, "using a model similar to the MHCC's Opening Minds initiative. That is, first get some understanding of what this stigma looks and feels like on the front line. Then identify existing initiatives and programs that are dealing with the problem, evaluate their effectiveness, and scale up and promote the best-in-class."

"I think it's safe to say that the stigma we're battling with the opioid crisis is beyond anything in mental health. The challenge is that much greater and the need for education that much more urgent."

As it happens, learning about stigma led to some stark results. But they shed light on how a lack of understanding about the root causes of addiction, compassion fatigue, and burnout, as well as entrenched stigma, are affecting first responders' ability to do their job – and also how people seek help.

"I think it's safe to say that the stigma we're battling with the opioid crisis is beyond anything in mental health. The challenge is that much greater and the need for education that much more urgent."

For example, while harm reduction efforts are working, they aren't reaching everyone. Safe consumption sites tend to be used only by people living within

one kilometer. Knaak said, “We’re also learning that upwards of 80 per cent of overdoses aren’t happening on the streets. The stereotype of people dying in their cars or behind closed doors is far less common. The shame associated with drug use drives people to hide.

“For our research, we went around the country and sat with groups of first responders, health-care providers, and people with lived experience of opioid (and other drug) use to try and untangle this complex interaction,” said Knaak. The responses we had ranged from moral ambivalence around overdose treatments like naloxone, which is feeding compassion fatigue across emergency departments and the first-responder community, to high levels of mistrust about the health system among people who use, especially marginalized populations.

“We heard so many people say they actively avoid health care and other services because of past experiences. They spoke about being mistreated, degraded, and being made to feel unworthy of care.”

As Knaak sees it, her mission is to destigmatize substance use. “There are so many misperceptions, misconceptions, and missed opportunities. We’ve got to understand where people are at and meet them there. We need to create an environment where people are unafraid to seek help, where they feel safe when they do reach out, and where there is access to high-quality best practice treatment for all.”

3 IN 4 PEOPLE
say **mental health care** is an **important priority**

Now that this brand of stigma is better understood, Knaak and her team are turning their attention to the next challenge: What can be done about it? Having evaluated four different kinds of interventions to reduce opioid-related stigma, they are poised to build on that progress.

“We’re also learning that upwards of 80 per cent of overdoses aren’t happening on the streets. The stereotype of people dying in their cars or behind closed doors is far less common.”

“We are now going to develop a strategy to scale up, promote, and adapt what works,” she said.

Bradley believes that “substance use-related stigma has met its match. If anyone can help lead this fight, it’s Stephanie. Not all superheroes wear capes.”

04

Susan Boyce: Unmasking the voices of lived experience

On July 16, 2019, the MHCC hosted a community-based research forum on cannabis and mental health to identify gaps and priorities and inform investments. Among the 63 attendees who came to Ottawa that day from across Canada, many were people with lived experience. Susan Boyce was one of them.

While excited to participate, Boyce initially thought her role would be to educate and advocate for the value of lived experience among a group of ivory-tower academics.

"I actually went to the forum expecting that I would be getting up and saying 'I object!' a lot. I thought I'd be raising the flag, saying 'this isn't really the way we should be speaking about people, this is not helping.' But I was blown away by how wrong I was," said Boyce, who is active in the mental health and addiction community as a both a professional and volunteer.

"My involvement with the mental health community was part of my own recovery. I really saw a lot of gaps and wound up going back to college. I was already a university graduate, but I earned a graduate diploma in psychosocial rehabilitation (PSR) at Douglas College in Vancouver. After that, I joined the board of PSR British Columbia."

It was that role which led Boyce to an awareness of the MHCC, and a desire to learn more.

"In B.C., when we were first going through what became a huge opioid crisis, I was very interested in finding out what was going on, because I worked with people every day who were affected by this, and I wanted to educate myself to help my community. My interest in addiction and cannabis use really grew during this time. So when I was invited to attend the forum, I jumped at the chance."

Boyce was humbled by the appreciation and respect accorded to the lived experience perspective, especially because she knows that while lived experience is part of the human experience, people in positions of influence can quickly become divorced from that part of their education.

"It's extremely important to have lived experience involved at all levels. There are a lot of people with degrees lecturing and teaching in this area, and many of them do have lived experience. But at some point in peoples' careers it's not talked about anymore. That's part of the stigma busting I'm trying to get people to think about."

Louise Bradley, MHCC president and CEO, agrees. "People like Susan keep me honest. For a long time I hid my own lived experience for fear of shame and stigma. When I began to talk about my life on both sides of the care divide, as a patient of mental health services and a clinical provider, I started connecting with people on a much deeper level."

"For a long time I hid my own lived experience for fear of shame and stigma. When I began to talk about my life on both sides of the care divide, as a patient of mental health services and a clinical provider, I started connecting with people on a much deeper level." – LOUISE BRADLEY, MHCC PRESIDENT AND CEO

And that's precisely what the effort to include lived experience in all MHCC research seeks to do.

"The only thing more heroic than walking the road to recovery from mental illness or substance use is using the wisdom born of that experience to help others," Bradley affirmed.

Boyce understands that challenge firsthand. "For the longest time," she said, "even though I felt very passionately about stigma, I didn't feel comfortable letting employers, or anybody else in a position of authority over me, know anything about that side of myself. Even though I knew it was wrong, it can still curtail your progress in Canada."

These days, she is starting to feel more empowered to share her story. "I feel more supported to stand up and say something, but it's definitely something we're still working on in this country. It's good to see the MHCC taking steps toward changing it."

After the forum, Boyce described it as a highly interactive experience, where information and knowledge were openly shared among the diverse group in attendance.

"It was just an incredible experience. The perspective of the people with lived experience was included, and not as an aside or a special thing. It was just part of the community of research, as it should be. I walked in thinking I was going to be surrounded by people who see things very differently from me. Instead, it was the complete reverse."

Bradley couldn't agree more about the value of achieving that kind of exchange. "We are so lucky to benefit from the rich perspective of lived experience. It's the generosity of spirit that continues to amaze me. People freely sharing their hard-won lessons learned with the goal of improving things for others. Talk about heroic."

Become a hero

Here's how you can help.

Become trained in Mental Health First Aid

If someone were experiencing a mental health crisis, would you know how to help? Join the more than 80,000 Canadians who took Mental Health First Aid this year and became part of a movement 500,000 strong.

Attend The Working Mind Training

Champion mental health in the workplace with The Working Mind! Bust stigma and learn to recognize signs of mental distress in yourself and others. This year alone, more than 23,000 people took TWM while more than 14,000 first responders took the course designed just for them.

Learn about our education-based initiatives

The Post-secondary Student Standard is poised to take campuses by storm. HEADSTRONG summits are equipping high school students with stigma busting tools.

Effectively engage with decision makers

Are you already working to improve the mental health and wellness of people living in Canada? Do you know how to secure government support? Check out the Government Engagement toolkit which provides the strategies, guides, and tools that can be used to ensure successful government engagement.

Stay connected

Sign up for our monthly newsletter, *Catalyst*, to keep up to date on new events, webinars, reports, and interviews, or follow us on Twitter, Facebook, and Instagram.

Year at a Glance

APRIL 2019

- Dévora Kestel, Director of Mental Health and Substance Abuse at the World Health Organization visits MHCC
- Northern Perspectives event at the Kwanlin Dün Cultural Centre in Whitehorse

MAY 2019

- Twitter livestream of mental health and substance use on campuses
- Launch of Caring for Healthcare toolkit

JUNE 2019

- Men's Mental Health on the Hill event

AUGUST 2019

- Waterloo-Wellington community signs on to Roots of Hope
- Louise Bradley is appointed to the Order of Canada

SEPTEMBER 2019

- MHCC hosts national Roots of Hope launch in Ottawa
- Release of Stepped Care 2.0 Demonstration Project report
- Release of Government Engagement Toolkit
- Release of Rainbow Youth Forum Report
- Release of Cannabis and Mental Health: Priorities for Research in Canada
- MHCC and the Canadian Mental Health Association announce strengthened collaboration

OCTOBER 2019

- The Inquiring Mind Post-Secondary training goes countrywide
- Post-Secondary Students Standard (PSSS) public review
- Focus group is held for PSSS
- First Nation, Inuit and Métis focus group for PSSS
- Francophone focus group for PSSS

NOVEMBER 2019

- MHCC hosts Issues of Substance Conference in Ottawa
- The Working Mind course demonstration event in New York City

DECEMBER 2019

- Release of special edition Catalyst newsletter encouraging volunteerism

JANUARY 2020

- Release Nanos Research polling data

FEBRUARY 2020

- Launch of Culturally Adapted Cognitive Behaviour Therapy for Canadians of South Asian Origin

MARCH 2020

- MHCC co-hosts E-Mental Health Conference in Toronto
- National Forum to improve mental health services and supports of people who are involved with the criminal justice system is held in Winnipeg
- MHCC staff begin working from home due to COVID-19 pandemic

Financials

Statement of Financial Position

As at March 31	2020 $	2019 $
ASSETS		
Total current assets	8,196,375	7,230,516
Capital assets, net	1,083,517	859,117
	9,279,892	**8,089,633**
LIABILITIES AND NET ASSETS		
Total current liabilities	5,132,558	3,862,827
Deferred capital contributions	190,451	215,015
Deferred tenant lease inducements	1,159,941	1,059,526
Total liabilities	**6,482,950**	**5,137,368**
Net assets		
Unrestricted	2,796,942	2,952,265
	9,279,892	**8,089,633**

Financials

Statement of Financial Position

As at March 31	2020 $	2019 $
Revenue	**23,431,252**	23,119,992
Expenses	**23,586,575**	**22,096,254**
Excess (deficiency) of revenue over expenses for the year	**(155,323)**	1,023,738
Net assets, beginning of year	**2,952,265**	1,928,527
Net assets, end of year	**2,796,942**	**2,952,265**

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 meetings day/yr)
Chair (for all Board and Committee duties)	$24,000	N/A	N/A
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 and CEO	$220,000	$245,000	$316,000
Vice Presidents	$144,000	$160,000	$200,000
Directors	$111,600	$124,000	$155,000

Mental Health Commission of Canada

Commission de la santé mentale du Canada

Mental Health Commission of Canada

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