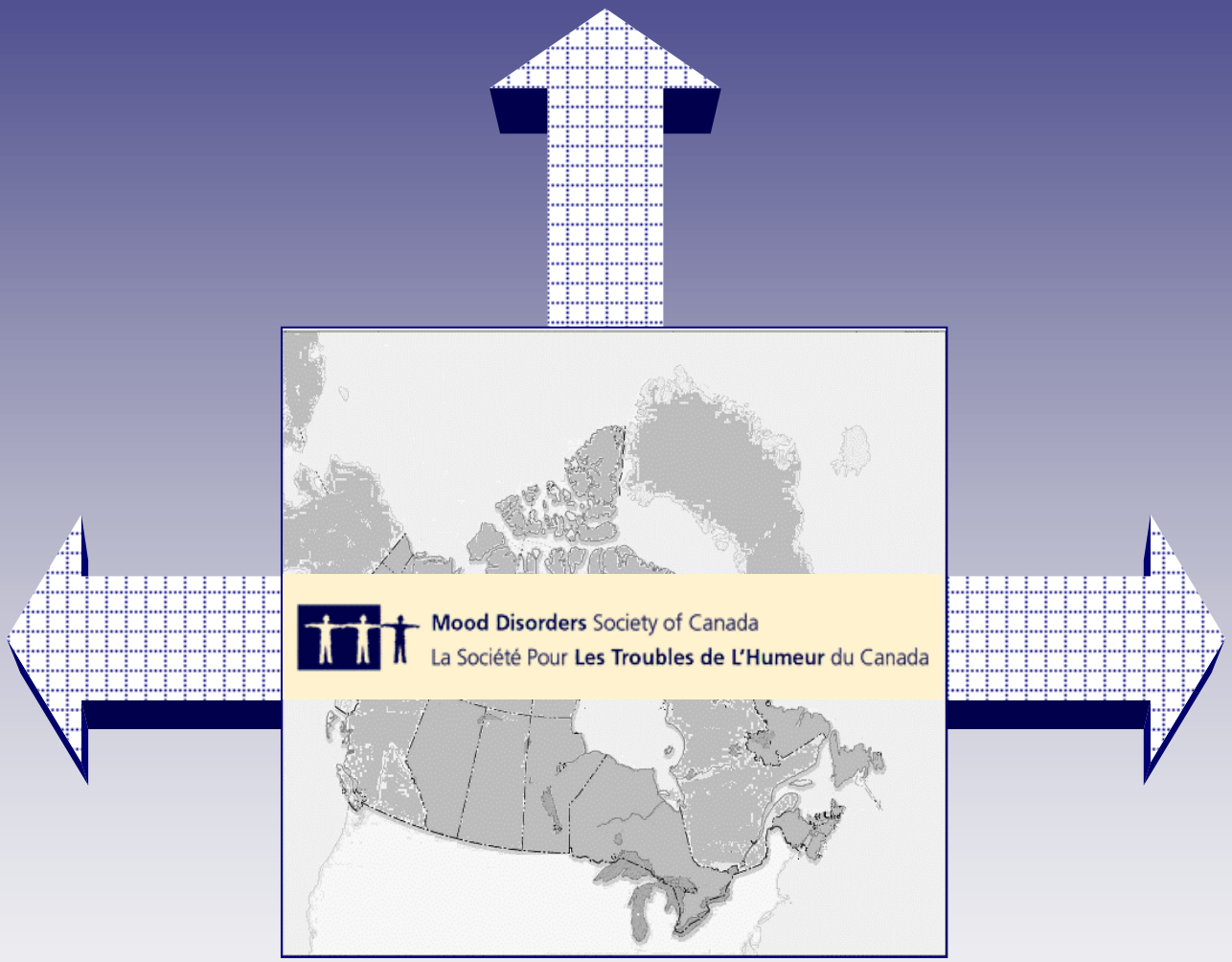
A Blueprint for National Action
on Mood Disorders in Canada



August 2004

www.mooddisorderscanada.ca

MOOD DISORDERS SOCIETY OF CANADA

A BLUEPRINT FOR NATIONAL ACTION ON MOOD DISORDERS IN CANADA

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I EXECUTIVE SUMMARY

The Mood Disorders Society of Canada (MDSC) is a national, not for profit, consumer driven, voluntary health charity committed to ensuring that the voice of consumers, family members and caregivers is heard on issues relating to mental health and mental illness and in particular with regard to depression, bipolar illness and other associated mood disorders. MDSC was formally launched and incorporated in 2001 with the overall objective to provide people with mood disorders with a strong, cohesive voice at the national level to improve access to treatment, inform research, shape program development and government policies to improve the quality of life for people affected by mood disorders.

The MSDC is primarily a virtual organization utilizing technology to build a well-linked, engaged virtual community with a small, cost-effective infrastructure. The virtual nature of the organization allows it to bring people together, particularly through information technology, to respond quickly and easily to emerging needs and overcome the geographic barriers that limit participation. As a result, MDSC has developed and hosts a widely respected and frequently accessed interactive mental health website.

Collaboration is a core MDSC operational principle. The Society fulfills its mandate through an active partnership approach that engages like-minded organizations in the public, private and voluntary sectors. MDSC is engaged on an ongoing basis in a wide range of projects and initiatives designed to support the inclusion of persons with disabling mental illnesses in Canadian society and has taken a lead proactive role in public policy and program development in many capacities on the national stage. Refer to MDSC's website at: www.mooddisorderscanada.ca for more details on innovative programs, services and national strategic research initiatives.

Following two years of extensive consultation and focused planning, MDSC developed a comprehensive planning framework in July 2003 to address major issues affecting consumers and their families in Canada. In order to incorporate these objectives within a national planning framework from a consumer and family perspective, the MDSC requested and received funding through the Social Development Partnership Program of the Office for Disability Issues of Social Development Canada to develop the Blueprint for National Action on Mood Disorders. The intent of the Blueprint is to formulate a national action plan that will achieve the eight overarching long-term objectives articulated in the report.

The national action plan is the result of an extensive consultation process and a successful and unique experiment in national policy development. The report provides details related to four major components of the planning process:

- Two planning initiatives, the Council of the Provinces and the National Scientific and Cultural Consultation, which were convened in Ottawa in March and April 2004.
- An independent process evaluation.
- A focused strategic planning forum of the MDSC Board of Directors.

The inaugural meeting of the Council of the Provinces was held in Ottawa on March 4th and 5th 2004. Provincial associations, self-help and peer support leaders from across Canada joined MDSC in identifying opportunities aimed at strengthening and expanding the mood disorders movement in Canada, engaging consumers and caregivers in planning and examining a range of options surrounding the future and ongoing role of the Council of the Provinces and its relationship with MDSC.

Participants felt that it was critical to develop one voice and one message with a common philosophy and mandate for mood disorders and a shared communications strategy. They agreed that growing the movement will take a multi-level approach with specific and planned activities at the national, provincial/territorial and local levels. Participants also felt it is appropriate that the MDSC serve as the national voice for advocacy for those affected by mood disorders and in providing public education. There was also a broad consensus about the important leadership role that MDSC can play in coalition and capacity building, both within and between sectors and in under-serviced areas throughout Canada

On April 15 2004, the MDSC was joined by representatives from provincial associations and some of its national partners in a successful experiment in public policy development in a first of a series of National Scientific and Cultural Consultations. A distinguished panel of experts provided MDSC's Directors and other attendees including representatives from the Social Development Canada and Health Canada with compelling key messages and guidance on issues related to mood disorders and seniors, youth, aboriginal, spirituality, mental illness in the workplace and scientific research. Michael Decter, Chair of the Health Council of Canada, indicated in his keynote address that the national objectives and activities of the MDSC were extremely important within the overall context of the Canadian health care system. He invited MDSC to work collaboratively with the Health Council of Canada and made a number of suggestions that could assist in defining a potential relationship.

Immediately following the National Consultation the MDSC Board of Directors and staff engaged in a focused strategic planning session, which led to a shared national vision and agenda. Items for further action fell into four main categories:

⇒ Education and Advocacy
⇒ Coalition and Capacity Building
⇒ Research
⇒ Organizational Capacity Building

Details of the Board's deliberations on these issues along with highlights from the interim process evaluation are described in detail in the following report.

The evaluation notes that*: "Most of the proposed MDSC roles and responsibilities align with MDSC's vision of itself as a virtual organization. Further refinement in its use of web-based technology will support coalition-building activities and provide MDSC with an effective forum for public education, research and knowledge translation, targeted intervention strategies, and the establishment of ad-hoc partnerships and alliances through virtual connections for specific projects and initiatives."*

Priorities for Future Action

The MDSC Board of Directors has subsequently developed a four-point policy framework and action plan, which will guide the emerging national organization in the ensuing months and years. The action plan will be driven primarily by the continued effective utilization of technology supported by sustained and meaningful partnerships and coalitions throughout Canada. The policy framework and action plan cover:

- Governance and organizational capacity
- Development as a virtual national organization
- Coalition and capacity building within and between sectors
- Leadership Role – Engaging in Relevant Research

Conclusion

The capacity building initiative on mood disorders in Canada has been a tremendous success and represents the first time in Canadian history that a national planning framework aimed at addressing major issues facing consumers and their families affected by mood disorders has been formulated. By bringing participants together we have defined a shared vision for the MDSC, strengthened the links between the national, provincial, and territorial consumers group and focused our collective energies to achieve shared goals.

The endeavor also included a unique and successful approach to policy development, namely the National Scientific and Cultural Consultation, which must be fostered and expanded in the years to come. By bringing together leading experts from diverse fields of study, with the self-help consumer leadership, we achieved greater agreement on our shared goals, purpose and a shared and integrated vision of how to improve the quality of life for consumers and families through partnership. These activities both strengthened support for the MDSC and energize and focus the efforts of the voluntary Board leadership.

The Board and staff of the Mood Disorders Society of Canada would like to express deepest appreciation to the provincial leaders of the mood disorders movement in Canada for their meaningful contribution and leadership in representing the best interests of Canadians and also to MDSC national partners.

The compelling messages from expert advisors have effectively set the stage for MDSC and its national and provincial partners to meet the many challenges and to take

advantage of the numerous opportunities that lie ahead for the mood disorders movement in Canada.

This Blueprint for National Action on Mood Disorders in Canada will serve to strengthen the mood disorders self-help/peer support movement in Canada over the course of the next three years as well as allowing consumers and their families to have an active national voice in the development of social and health policies and programs.

Finally, MDSC would like to formally acknowledge and express sincere appreciation for the financial support and encouragement received over the past year from the Office of Disability Issues of the Department of Social Development.

II MOOD DISORDERS SOCIETY OF CANADA

HISTORY AND OVERVIEW

The Mood Disorders Society of Canada (MDSC) is a national, not for profit, consumer driven, voluntary health charity committed to ensuring that the voice of consumers, family members and caregivers is heard on issues relating to mental health and mental illness and in particular with regard to depression, bipolar illness and other associated mood disorders.

The Mood Disorders Society of Canada (MDSC) has grown out of the vision and drive of a number of mental health consumer leaders from across Canada who in 1995 saw the need for a broad-based structure to bring consumers of mental health services together and who believe that consumers have a key role to play with regard to education and advocacy at the national level.

MDSC was formally launched and incorporated in 2001 with the overall objective to provide people with mood disorders with a strong, cohesive voice at the national level by:

- Raising the awareness of mood disorders as treatable medical disorders and work to eliminate the barriers to full community participation, discrimination and stigma among the public, treatment and service providers, and governments.

- Building a national clearinghouse of information and resources related to mood disorders issues.

- Advocating for the creation of adequate and accessible, stigma free programs for those Canadians living with or suffering from a mental illness.

- Ensuring that the voices of consumers and family members are accurately understood and communicated on issues of national importance by building on existing networks and alliances.

MDSC is governed by a national Board of Directors, the majority of whom are consumers. It has evolved to become one of Canada's best-connected mental health NGOs with a demonstrated track record for forging and maintaining meaningful and sustained partnerships with the public, private and non-profit sectors throughout Canada. MDSC is a founding member and provides leadership to the Canadian Alliance on Mental Illness and Mental Health (CAMIMH), whose member organizations include: The Autism Society of Canada; Canadian Association for Suicide Prevention; Canadian Coalition for Seniors' Mental Health; Canadian Federation of Mental Health Nurses; Canadian Psychiatric Association; The Canadian Psychological Association; Canadian Mental Health Association; The Mood Disorders Society of Canada; National Network for Mental Health; The Native Mental Health Association of Canada; and the Schizophrenia Society of Canada.

The Society's President, Mr. Phil Upshall is also a member of the Statistics Canada's Expert Panel and the Advisory Board of the Institute of Neurosciences, Mental Health and Addiction (INMHA), and is an adjunct professor in the department of psychiatry at Dalhousie University. He is a "distinguished advisor" to the Global and Business and Economic Roundtable on Addictions and Mental Health and received a 2003 National Award Recipient from the Council of Canadians with Disabilities in recognition of his 'Valued Contribution to the Disability Rights Movement in Canada.'

The MSDC sees itself as a primarily virtual organization with a small, cost-effective infrastructure. The virtual nature of the organization allows it to bring people together, particularly through information technology, and to respond quickly and easily to emerging needs. As a result, MDSC has developed and hosts one of the most widely accessed interactive mental health websites in Canada. Recently the site was visited over 500,000 times (this number differs from other submissions which I think was 330,000) in a four day period after CTV aired its program called "Fighting the Dragon", a television documentary dealing with depression.

Collaboration is an MDSC operational principle. The Society fulfills its mandate through an active partnership approach that engages like-minded organizations in the public, private and voluntary sectors. MDSC is engaged on an ongoing basis in a wide range of projects and initiatives designed to support the inclusion of persons with disabling mental illnesses in Canadian society and has taken a lead proactive role in public policy and program development in many capacities on the national stage. Refer to MDSC's website at: www.mooddisorderscanada.ca for more details on innovative programs, services and national strategic research initiatives.

III TOWARDS A BLUEPRINT FOR NATIONAL ACTION

BACKGROUND

Following two years of extensive consultation and intense focused planning, MDSC developed a comprehensive planning framework in July 2003 to address major issues affecting consumers and their families in Canada. The framework also served as the Society's response to a major report released in 2002 entitled "A Report on Mental Illness in Canada" which was published by Health Canada and the Mood Disorders Society of Canada in collaboration with nine national partners.

To incorporate these objectives within a national planning framework from a consumer and family perspective, the MDSC requested and received funding through the Social Development Partnership Program of the Office of Disability Issues of the Department of Social Development to develop a National Blueprint for Action on Mood Disorders.

The intent of the Blueprint is to set out a national action plan, which will achieve the following long-term objectives:

- To strengthen and expand the mood disorders self-help/peer support movement in Canada.
- To establish and support the ongoing development of a Mood Disorders Council of the Provinces which will collaborate with MDSC in promoting best practices and lessons learned throughout Canada.
- To develop a Blueprint for National Action based on a series of priorities which will ultimately ensure equity of all mental health/illness programs and services to all Canadians in a cultural/linguistic appropriate manner.
- To develop provincial/territorial associations or linkages in the areas of Canada where none exist today.
- To bring mood disorder consumers/caregivers together with the Canadian research community to deal with common issues in areas related to mood disorders at a national level.
- To engage consumer/caregivers in identifying the barriers they see to full participation in Canadian society and empowering them to participate in planning and policy processes.
- To ensure the Mood Disorders Society of Canada is able to communicate directly and with credibility the concerns facing consumers and caregivers to professional organizations and associations within the Canadian Alliance on Mental Illness and Mental Health.
- To ensure that consumers and caregivers living with depression, bi-polar disorders and related mood disorders have an active national voice in the development of social and health policies and programs

The following Blueprint has been developed within the context of two major planning initiatives: the Council of the Provinces and the National Scientific and Cultural Consultation initiatives convened in Ottawa in March and April 2004. The Blueprint was also informed by an independent evaluation and a focused strategic planning forum of the MDSC Board of Directors.

IV COUNCIL OF THE PROVINCES

Participants

MDSC held the Council of the Provinces conference in Ottawa on March 4 & 5, 2004. Conference participants included representatives from the following provincial organizations:

- **Mood Disorders Association of British Columbia**
  Ed Rogers, President
  Vicki Rogers, Executive Director

- **The Organization for Bipolar Affective Disorders Society (OBAD), Alberta**
  Dave Lapsley, Chairman
  Kaj Korvela, Executive Director

- **Anxiety and Mood Disorders Program, Saskatchewan**
  Lana Shaw-Ethier, Nurse Therapist/R.P.N.
  Friends and Relatives of People with Mental Illness (FROMI)
  Elaine Malkin, Steering Committee Member

- **Mood Disorders Association of Manitoba**
  Bev Trachuk – Executive Director
  Doreen Johnson, Outreach Worker – Psych Health Winnipeg

- **Mood Disorders Association of Ontario (MDAO)**
  Karen Liberman, Executive Director
  Trish Stenson, Director – “Our Sister’s Place”

- **AMI-Québec Alliance for the Mentally Ill**
  Ella Amir, Executive Director
  Lorna Moscovitch, Vice-President

- **REVIVRE – Québec Anxiety, Depressive and Bipolar Disorder Support Association**
  Jéan-Remy Provost, Executive Director

- **New Brunswick - Our voice / Notre Voix & Groupe de support émotionnel Inc**.
  Eugene LeBlanc, Executive Director/Publisher

- **DayBreak Activity Centre, New Brunswick**
  Kathy Tapley-Milton, Writer

- **The Self-Help Connection, Nova Scotia**
  Linda Bayers, Executive Director
  Roy Muise, Participant Support Worker

- **The Canadian Mental Health Association, Consumer and Family Support Program, Prince Edward Island**
  Josephine Power, Consumer and Family Support Worker

Each organization provided an overview of its history, mandate and current activities. All of the organizations represent consumers and/or allies and friends of consumers. Not all are consumer driven, but all are driven by the condition of mental illness. Mandates differ somewhat and there are geographic disparities between provinces with some organizations much more heavily resourced than others.

Priorities

Prior to the conference, participants responded to an MDSC survey and identified priority areas for national action for mood disorders. The top five priorities were:

- Eliminating the stigma associated with mood disorders
- Advocacy
- Action on youth issues
- Mood disorders in the workplace
- Capacity building in under-serviced areas of Canada

Towards a National Agenda for Mood Disorders

Conference participants reviewed existing strengths, weaknesses, threats and opportunities for the mood disorders movement in Canada within the context of creating a national agenda.

Weaknesses and threats include ongoing stigma for those with mood disorders; chronic and persistent lack of funding; a lack of networking/cohesion at the national level; and the need for a national strategy to raise public awareness and advocate within government.

Key strengths are the commitment, passion, dedication and creativity of those working in the area of mood disorders and their evidence based experience, knowledge and expertise; the strong base of volunteer commitment and support; and the strength and power of collective consumer voices.

The emergence of linkages and partnerships between organizations creates opportunities to establish a national movement/coalition of provincial agencies and develop a sustained, effective campaign at the national level to raise public awareness and influence government.

Based on identified strengths and opportunities, participants provided input regarding strengthening and expanding the Mood Disorders Movement in Canada, engaging consumers and caregivers in planning, and the future role of the Council of the Provinces and its relationship with MDSC.

To strengthen and expand the Mood Disorders Movement in Canada, it is critical for participating organizations to develop one voice and one message. There must be a national philosophy and mandate for Mood Disorders and a shared communications strategy. Growing the movement will take a multi-level approach with specific actions and activities at the national, regional and local levels. The provision of material support from the MDSC will play a key role through the creation of a virtual connection with an interactive element and dissemination of material from programs across the country. Provincial organizations need to take advantage of these connections to link with each other and work more collaboratively.

To engage consumers and caregivers in planning, the barrier of stigma must be addressed. Stigma is not just a personal issue**.** Organizations need to advocate within their own communities and beyond about the importance of speaking out. Public awareness must be raised – strong anti-discrimination laws would go a long way in protecting professionals from sanctions for speaking out. Specific actions and strategies can make it easier for consumers and caregivers to disclose, including engaging consumers and family members in a way that is comfortable and supportive; ensuring that consumers and caregivers have support/self-help at the local level; building strengths through training and leadership development; and talking openly with consumers and caregivers at the right time about the risks and benefits related to speaking out.

The establishment of a Council of the Provinces will occur within the context of the questions:

- How would the world be better if we had a Council of the Provinces?
- What is the role of the Council and who comprises the Council?
- What is the relationship between the Council and the MDSC?
- What is positive and possible within the next 3 years?

Preliminary Statement of Principles for the Council of the Provinces

Goals:

- To establish a national coalition with a single voice (a Council of the Provinces), which will develop a national campaign to raise public awareness, advocate on behalf of those with mood disorders and influence government.

- To develop linkages and partnerships between participating organizations to share information, resources, and knowledge.

Possible Role of the Council of the Provinces:

- To advise the MDSC on the following issues:
  - The creation of a national voice to eliminate the stigma of mood disorders, advocate for people with mood disorders, lobby governments and raise public awareness.
  - Capacity-building in under-serviced areas of the country.
  - Capacity-building within provincial organizations through inter-agency information, knowledge and resource sharing.

Relationship of the Council of the Provinces with the MDSC:

- To serve in an advisory capacity to the MDSC on the issues described above.
- The Council of the Provinces may or may not have some formal representation on the MDSC, but the MDSC will expand its membership to be more broadly representative of all regions of Canada.

Frequency of meetings:

- Assuming sufficient resources, the Council of the Provinces will meet once annually.

V NATIONAL SCIENTIFIC AND CULTURAL CONSULTATION

Participants

A National Scientific and Cultural Consultation was held on April 15, 2004 in Ottawa with a cross-section of leading Canadian researchers and service providers. A reception and dinner followed the presentations and discussions. Michael Decter, Chair of the Health Council of Canada, was the keynote speaker.

The MDSC Board of Directors, management and staff were joined by following national and provincial partner organizations and funders

Joan Montgomery
CEO, Schizophrenia Society of Canada
Francine Knoops
Canadian Psychiatric Association
Constance McKnight
National Executive Director – National Network for Mental Health
Dr. John Service
Executive Director, Canadian Psychological Association
Bev Trachuk
Mood Disorders Association of Manitoba
Robert Winram
Mood Disorders Association of British Columbia,
Roy Muise
The Self-Help Connection, Nova Scotia

Ella Amir
AMI-Québec Alliance for the Mentally Ill
Kaj Korvela
The Organization for Bipolar Affective Disorders Society, Alberta
Eugene Leblanc
The Self-Help Centre, New Brunswick
Nicole Gedesk
Youthnet – Calgary, Alberta
Ellen Ellesmore
Youthnet - Ottawa, Ontario
Nishad Khanna
Centre of Excellence for Youth
James Goverde
Corrections Officer, Toronto Don Valley Jail
Carol Levesque
Program Advisor, Office of Disability Issues, Social Development Canada
Claudette Perron
Manager, Office of Disability Issues, Social Development Canada
Jean Pruneau
Manager, Health Promotions Unit, Health Canada.

Presentations

(See Appendix A, for biographies of presenters and MDSC board members)

5.1 Mood Disorders and the Workplace

Barbara Jaworski
WorkLife Solutions and Well Being, FGI

Key Issues

Mental health is very much a workplace issue. The workplace is inherently stressful and every workplace has employees with a mental illness or some history of mental illness.

Mental health problems in the workplace are increasing and the needs of employees are changing. The costs of treating mental illness are exploding for workplaces. Short-term disability leave due to mental illness has risen over the past few years from 30% to 50%. Benefit costs for medications related to anxiety and depression are increasing rapidly. Social changes such as rising divorce rates and an aging workforce are creating new challenges for employers and employees. Employee Assistance Programs are seeing many more people with mental health problems related to reconstituted families, childcare and parenting issues and elder care. The employee population is aging and many would prefer not to retire, but the workplace is not structured to support them.

Many employers know that they have an issue with mental health in the workplace, but it is still very much a well-kept secret. About 70% of employers have Employee Assistance Programs, however, not all employers tell their employees about these programs and a smaller number actively promote the use of the programs.

Supportive environments are protective of mental health. In our society and in the workplace, we expect people to be independent, efficient and goal oriented. However, people intuitively know that social support and family connections are important. Those with supportive employers and good social and family supports can usually manage mental health challenges; others with fewer supports will have difficulty coping.

Employers must be educated about the importance of prevention and early intervention. The more support employees receive with regard to alleviating the stress of day-to-day functioning, the fewer will require disability leave, resulting in significant savings and increased productivity in the workplace. Progressive employers recognize this and use EAP programs for prevention and early intervention.

Effective prevention and intervention includes teaching employees to nurture and care for themselves and teaching managers how to support staff. Self-care includes information about healthy lifestyles, effective coping skills, etc. Organizations who take this approach to keep employees well are seeing the benefits. Progressive employers also support teaching managers how to be effective managers. The quality of the manager is key to employee mental health. Good managers protect their employees, provide them with support and give them permission to be human – to have problems, to seek help and ultimately to get better.

Advice to MDSC

The time to act is now. Because of the rapidly rising costs of mental illness in the workplace, employers are now open to listening to groups like the MDSC – there is an opportunity here to appeal to their need to reduce costs. Organizations are also keen to position themselves as ethical and humanitarian and as having a social conscience, so they will be likely to welcome consumer input.

Communicate with employers in a way that is meaningful to them. Focus on the fact that mental health is a rapidly growing and costly workplace issue – there is an opportunity here to appeal to the employer's need to reduce costs. Emphasize that prevention and early intervention are critical in reducing the burden of mental illness in the workplace. **This includes employee self-help and self-care and the use of EAP programs for prevention and early intervention.**

Emphasize that good management is highly protective of employee mental health. Direct managers are the most important resource for safeguarding employee health in the workplace on a day-to day-basis. Training managers to support the mental health of employees is critical. Having senior managers from progressive organizations speak to managers from other organizations would likely be an effective change strategy.

5.2 Mood Disorders and Seniors

Dr. Catherine Shea
Vice- President, Canadian Academy of Geriatric Psychiatry

Key Issues

The elderly is a rapidly growing group with specific issues related to mental health. It is not unusual for physicians to under-diagnose mental illness in the elderly. For example, symptoms that are attributed to "age related" mental deterioration are often actually caused by depression. Untreated mental disorders are a common cause of placement in nursing facilities and can contribute to difficulties with rehabilitation from a physical illness, e.g. a stroke. They also lead to higher death rates, and men over the age of 80 are the most successful in committing suicide. At the same time, the elderly are often over-medicated, which can also affect mental health. There is no quick fix for mental health problems – as consumers we have to educate our doctors that a pill or pills are not the quick solution to every problem.

The elderly have unique risk factors for mental illness. They often have multiple health problems. Risk factors for mental illness include dealing with the stress of a physical illness or illnesses and having to take medications that contribute to mental illness.

It is often difficult for the elderly to receive adequate care, especially in rural areas and small communities. There are not enough family physicians and many young doctors in training are not interested in becoming family physicians. Family doctors also need adequate support from specialists. We need a team approach in order to treat mental illness holistically, but there are not enough teams available.

The stigma of mental illness is compounded by the stigma of being old. People devalue the importance of mental health for the elderly. Thoughts such as "I would be depressed too if I were old and sick" reflect ageism. Mental health is important for all.

Advice to MDSC

Educate the public and family members about mental illness and the elderly and advocate for the needs of the elderly, including access to appropriate care.

5.3 Mood Disorders and Spirituality

Dr. Jordan Peterson
University of Toronto

Key Issues

In examining and treating mental disorders, we need to differentiate spiritual perspectives from other perspectives. As a society, we have made a lot of progress in the material/scientific understanding of mental disorders. However, values and ethics are not in the material/scientific realm and questions related to this realm cannot be answered by science.

There are two approaches to religion, each of which has an influence on our mental health and our perspectives on how to assess and treat mental illness.

The first approach is traditional/dogmatic, emphasizing teaching and promoting higher-order values such as justice and kindness. Tradition and dogma set the ground rules for human interactions and help people to people to orient themselves in the world. They also help individuals deal with each other in a way that makes society work more effectively, while reducing conflict and dispute, which are stressful and potentially dangerous. The second is the mystical approach, which views the human being as a being who, in his or her essence, confronts uncertainty and chaos and engenders new order and meaning from it.

The mystical approach is practically more useful in considering the relationship between spirituality and mental illness.

Everyone has idiosyncratic and limited belief systems that they use to orient themselves in the world. A confrontation with chaos, in the form of a catastrophic event – a trauma, illness, or significant loss – challenges established belief systems, which can cause negative and painful emotions to surface and overwhelm the person, precipitating a mental or a physical illness. When a well-developed belief system collapses, due to a catastrophic event, the brain structures that govern the stress response are activated, producing fear and restriction of attention to the present. The areas of the brain that react to trauma in this way are basic survival systems that we share with lower animals. This is useful for moment-to-moment responses and short-term survival. However, if the person is unable to process and integrate the event, the stress response will be chronically activated, and stress hormones will continue to be produced. Over the long term, the chronic production of stress hormones such as cortisol, damage the immune system, causing physical disease, damaging memory systems and producing complex anxiety disorders and depression.

In the treatment of mental illness, anti-depressants such as Selective Serotonin Reuptake Inhibitors (SSRIs) work, in part, by normalizing cortisol production and helping brain tissue damaged by cortisol to recover. Research also shows that processing the trauma through revisiting the original experience and integrating it into a more coherent sense of meaning and purpose enables higher-level brain systems to regulate and control the lower areas that govern the stress response. This allows the person to generate a sense of meaning and purpose from the event, shuts off the stress response and promotes healing, including a variety of improvements in immune function and mental health.

Guided, voluntary re-encounter helps the individual to develop a coherent narrative about the event. Such a narrative refines the original belief system into one that is richer and more integrated, transforming the chaos into order, and making sense of the experience. The higher-level narrative includes a plan, with strategies and goals that help to reduce uncertainty in the environment and related feelings of vulnerability. The re-encounter is therefore pragmatic as well as philosophically meaningful.

Spirituality provides a foundation and framework to support people in confronting uncertainty, chaos and pain, and deriving meaning from it. In this manner, it protects and promotes mental health. The mystical path, the second religious approach, posits a model of the human being as the individual who can stand up to social decadence and corruption and confront uncertainty and chaos. It is predicated on the assumption that traumatic experiences (uncertainty and chaos) are full of information, and that you can learn things about yourself and the world as a consequence of such experience that you could never imagine. Such an approach promotes and supports a courageous attitude to the unknown: if you confront it you learn from it; if you run away from it, it chases you.

In this sense, spirituality is also important in preventing the onset of mental illnesses in young people. In the education system we do a very poor job of helping young people develop long-term coherent plans that include well thought out value systems. Positive emotion is largely related to having specific goals and a coherent philosophy of life.

Advice to MDSC

Emphasize the importance of helping young people to develop long-term plans with specific goals within the context of a coherent philosophy of life.

Stress the importance of coherent reward systems in the workplace. Rules need to be clear and predictable so that people can learn to organize their behaviour accordingly and obtain a sense of meaning and value from their work.

These issues – lack of meaning and purpose, and lack of a cultural value system – are particularly relevant to aboriginal populations, and to substance abuse and addiction. We know that drugs and alcohol can produce positive emotion. The question is no longer “why do people abuse drugs and alcohol?” We know the answer do that. The question is “why don’t all people take drugs and alcohol all the time?” The answer to that is “because they have a richer and more sustainable alternative – something better waiting in the future.”

Educate people about the physical basis of mood disorders to reduce stigma. The more the physical basis of the disease can be understood, the more stigma will be reduced, and the less it will be perceived solely as a problem of will.

In addition to providing descriptive, diagnostic information, MDSC should also share information about the narrative-type interventions on-line (a structured self-help process that people could access themselves on-line.) There is valuable research available describing the narrative regulation of emotion that is not spiritual, *per se*, but is related to spirituality. Dr. Peterson would be interested in making these narrative interventions widely available.

5.4 Mood Disorders and Research

Dr. Remi Quirion
Scientific Director of the Institute of Neuroscience, Mental Health and Addiction, Canadian Institutes of Health Research

Key Issues

The CIHR wants to partner with the voluntary sector, working with NGOs and consumer organizations on knowledge translation and on developing specific research initiatives.

Small NGOs need to develop a larger network to be able to influence research and public policy. INMHA has the largest number of partner voluntary organizations of all of the institutes. However, they are all very small organizations – there is no one large one, such as the Cancer Society. We need to work together to change that in order to raise more funds from the public for research into mental illness.

We need to find champions and to raise public awareness to reduce the stigma associated with mental illness and addiction. One of the key initiatives of the institute is to find ways to decrease this stigma. It should be as easy to talk about mental illness as it is to talk about cardiovascular disease or cancer, and people should receive as much social support.

A lot of excellent research is being conducted in Canada on mental illness and addiction spanning a broad range of areas of investigation – these people need to be better networked. We need to support this and also promote the work of the next generation of scientists. **Input from the MDSC would be valuable in helping to develop the research agenda.** For example, the MDSC could support the development of a research program into spirituality and mental illness, which could be done in partnership with other institutes, such as Aboriginal People Institute.

Advice to MDSC

Partner with the CIHR and INMHA to turn challenges into opportunities by working together to educate the public, health care providers and bodies such as the Health Council of Canada. As part of this education, we must ensure that mental health is not separated from the issue of physical health.

The MDSC can help with knowledge translation by developing effective communication strategies that reduce the use of scientific jargon. The INMHA gave some small grants to NGOs last year to develop communications strategies with key stakeholders and/or the general public. The INMHA would be prepared to do more of this. It has an annual meeting every November with NGOs, trainees and scientists, where people affected by disorders speak to the group.

5.5 Mood Disorders and Aboriginal Communities

Dr. Brenda Restoule
Native Mental Health Association of Canada

Key Issues

There are many mental health issues in Aboriginal and First Nations communities. First Nations and Aboriginal people have a high incidence of physical illnesses, such as obesity, diabetes and cancer. Social conditions are often very challenging, many communities have a very poor standard of living, and many people are unemployed. Rates of family violence are very high – 80-95% of clients have family violence issues. These cases often present clinically as mental health issues such as depression.

People are connected to their communities, but resources are inadequate to support their needs, especially in rural and remote areas. Despite the challenges, people don't want to move away; they are very connected with their communities, homes and families. There is a strong comfort level there. Those who have moved away often want to come back, but the communities cannot support the level of skill and training required for effective interventions. For example, most communities, although they have significant mental health issues, do not receive sufficient funding to support a psychologist. This results in mental health problems being perpetuated from generation to generation. Also, much of the funding for Aboriginal Mental Health services is focused on urban populations and rural areas are under-serviced. This is the case even though people frequently move back and forth between urban centres and rural communities. Recently, we were told that our mental health dollars were going to be cut by the Ministry of Indian Affairs, but a grassroots campaign convinced them to change their minds.

One of the main causes of social and individual mental health problems for First Nations and Aboriginal communities is the loss of cultural identity, particularly as a result of the residential school experience. Almost all aboriginal communities have been affected by this and most have family members who are survivors. These experiences caused a great deal of trauma, not just because of abuse, but because there was a deliberate challenge to and destruction of the Aboriginal cultural heritage, language and traditions. Survivors lost their cultural identity, but found they were not accepted within the dominant culture either – they were still perceived as different and inferior. This loss of cultural identity, and the associated loss of personal meaning and goals, is clearly related to many complex issues, including mental illnesses, such as depression and PTSD, suicide, dysfunctional family relationships, addiction and substance abuse.

There is also a stigma in the communities related to accessing services. This is not just the stigma of mental illness, but also involves a culturally based reluctance to "burden" others with problems. The issue of confidentiality is also a problem in rural areas and small communities.

The Royal Commission on Aboriginal People showed that **Aboriginal people do not view mental health as separate from other areas of life – physical, emotional and spiritual.** The Medicine Wheel represents this holistic perspective. When working with people we try to ensure that all areas of their lives are balanced. We also use traditional practices to put people back in touch with their cultural heritage and to treat mental illness, such as help from elders and medicine people, using the sweat lodge, cedar baths, herbal medicines, etc. These have proven very healing for First Nations and Aboriginal people. Western knowledge is useful and has helped Aboriginal people, but others can learn a lot from our traditional teachings and practices as well.

Advice to MDSC

When working with Aboriginal people on education or advocacy, keep in mind that they do not view mood disorders in isolation from other life issues. They identify with and respect holistic approaches that include traditional healing practices. MDSC needs to consider the person and community holistically, including the social and economic conditions. Alternative methods of healing, such as traditional native interventions, may be as or more effective in treating mood disorders as psychotherapy and drugs.

Advocacy is needed for more resources for Aboriginal mental health, especially in rural, remote communities. Additional resources including the ability to access consultations from professionals who understand Aboriginal mental health issues are required. There is a need for more support for those working on the ground. Adequate resources for all people, regardless of where they live, are important.

5.6 Mood Disorders and Youth

Pytor Hodgson
Centre of Excellence for Youth Engagement and Students Commission of Canada

Key Issues

Mental illness is a problem for youth. Suicide accounts for 24% of all deaths for youth aged 15-24.

Effective youth engagement is protective. The Centre has been doing a lot of work on what youth engagement means for young people. We have found that if the process is effective, there are positive outcomes for young people, including preventing crime, helping youth to stay in school and helping youth with mental illnesses.

Young people are interested in participating in the work of organizations like the MDSC. There is often an assumption that youth are unable or unwilling to participate, however, this is unfounded. Youth are willing to participate if they are engaged in a meaningful way. It is extremely important to give youth a voice on this issue.

Advice to MDSC

For meaningful youth participation, look to existing initiatives/structures and access the resources that are already there. This would include approaching organizations such as Youthnet and the youth who participate in the discussion forums organized by the Centre.

Youth engagement is a process and sometimes a challenging process. It is not simply having a token 22 year old at the table. Sometimes you need to reach out, actively seek out young people and let them know that the organization is open to their input and needs their input and support. Approach them laterally – do not ask them to participate simply because they have a mood disorder – invite them to share their unique strengths, for example, public speaking skills. Consider using innovative ways of engaging youth and allowing them to shape the form of their own contributions, e.g. through electronic communication.

Develop aggressive education campaigns for youth to combat the issue of stigma. This is a big problem for youth, especially for young men. They believe they are supposed to be tough and strong and not need any help. We need to educate young people about mood disorders and create environments where they are able to come forward and speak openly about these issues.

Engage young people in research; have them help to shape the research agenda and conduct the research.

VI KEYNOTE ADDRESS

Mr. Michael Decter
Chair, Health Council of Canada

Mr. Decter provided participants with a comprehensive overview of the history of Canada's health care system leading up to the recent establishment of the Health Council of Canada and his appointment as Chair. He was very impressed with the compelling content of the key messages and the recommendations and advice provided by the expert panel to the Mood Disorders Society of Canada. He emphasized that the national objectives and activities of the MDSC are extremely challenging and important issues within the overall context of the Canadian health care system.

Mr. Decter further noted that the Health Council of Canada will be pursuing a national strategy that will be positive, proactive and inclusive and that its primary agenda would be focused on the identification of best practices in every region of Canada. He invited the MDSC and other NGO's to collaborate with the Health Council and to share best practices within the peer support/self help in Canada. He encouraged the consumer/survivor movement in Canada to suggest possible candidates for consideration at both the governance and operational levels of the Health Council as staff and Council positions become available.

VI MDSC BOARD OF DIRECTORS STRATEGIC PLANNING SESSION

The MDSC Board Strategic Planning Session was held immediately following the National Scientific and Cultural Consultation. The Board had a roundtable discussion on possible areas of focus for a shared national vision and agenda. Items for further action fell into four main categories: Education and Advocacy, Coalition Building, Research and Organizational Capacity Building.

Education and Advocacy

How will the MDSC communicate key messages?

1. Define the audience and target the message to the audience.

There are two key audiences: those directly affected by mood disorders (friends and family members); those indirectly affected (everyone else). When we speak out, we need to clearly identify which group we are talking to and make the message relevant to the listener. We are good at communicating with those directly affected. How do we get better at talking to everyone else? The MDSC needs to share information that shows how mood disorders are relevant to everyone.

2. Share messages that inspire hope.

We need to share stories of recovery and renewed hope and quality of life. We need to portray mental illness as a journey of hope. It is not sufficient to talk only about diagnosis and treatment, and we do not want to show people as victims or "just the illness".

3. Identify a national spokesperson.

4. Provide outreach and education through person-to-person contact and speaking engagements.

We need to use the voice of personal experience to build credibility, e.g. lawyers speaking to lawyers. We should also consider gender issues when reaching out – women are more receptive to acknowledging mental health problems than men are. Ensuring that people know that all information will be kept confidential is critical.

5. Develop an electronic newsletter posted on the website targeted at consumers.

6. Raise our media profile/engage the media effectively.

We need a long-term media strategy that will dispel the myths about mood disorders. Possible activities include:

- Assembling a media list and sending out regular media releases**.**
- Using innovative approaches, such as the "Dear Ellie" newspaper advice column.
- Using filler ads and PSAs.
- Finding a media champion.

What are the MDSC key messages?

1. Make the connection between mental illness and addiction.

We need to deal with the issue of addictions – this is a major problem for people with mood disorders, especially for youth and Aboriginal people. It is also related to gender differences in depression. These may, in fact, be a cultural artifact; in some cultures that do not use drugs and alcohol there are no gender differences in rates of depression. With regard to dual diagnoses, research shows that mental illness often precedes addiction by many years. Most addictions programs do not look for underlying mental illnesses. This is particularly relevant for Aboriginal populations. Many of their addiction problems are related to previous trauma. FASD receives a lot of attention, but no one looks at *why* the mother needs alcohol.

2. Make the connection between mental illness and other health problems.

Research shows that many health problems are associated with mental illness. For example, excluding risk factors such as obesity and tobacco use, a history of depression increases the risk for heart disease. Those with heart disease are also at higher risk for depression. People with chronic pain, such as arthritis, are more prone to depression. The information is all listed on the website dbsalliance.org and could be linked to MDSC website.

3. Emphasize the importance of early diagnosis, treatment, support and education.

This is particularly important for children and youth. We have to reach out to people where they are. Education to caregivers, such as family physicians and in the schools, including programming in the schools, is sorely needed. Education on mental illness should be a mandatory part of the school curriculum just as education on STDs is.

4. Advocate for a national mental health program for Aboriginal communities.

The MDSC needs to work with Aboriginal communities to identify priorities and promote appropriate training for professionals, especially culturally relevant training programs.

5. Promote the importance of spirituality and connectedness (belief and belonging) as key factors in prevention, recovery and mental health.

The MDSC should bring researchers and faith communities together and disseminate pertinent information, such as the mental health benefits of meditation.

6. Provide education and advocate for the needs of the homeless with mental illnesses.

The police need education in dealing with homeless people, many of whom have mental illnesses. We also need to advocate for appropriate resources for the homeless who are mentally ill, on the street and within the corrections system.

7. Emphasize the importance of education for professional caregivers in training

Coalition Building

The MDSC needs to build capacity within the sector and across sectors and facilitate the development of broad-based coalitions through non-traditional partnerships and approaches. Areas for action include:

- Encourage growth within the provinces by supporting the provincial organizations (Council of the Provinces) through information sharing, etc.
- Make linkages and break down barriers with religious communities.
- Build coalitions with Aboriginal groups.
- Challenge funding practices and traditions that encourage the creation and maintenance of "silos".

Research

The MDSC is committed to continuing to develop, implement and participate in relevant research initiatives such as the proposed mental illness and the workplace project, and to continuing in a lead role on key strategic research initiatives such as problem gambling. Future research will evolve based on priorities as set forth in this document and within the context of consultation and partnerships with national and provincial partners.

In addition MDSC will continue to support the efforts of the Institute of Neurosciences Mental Health and Addiction of the Canadian Institutes of Health Research by advocating for funding in priority areas and taking an active role representing our sector in specific research activities of the Institutes e.g. workplace, stigma. Through the MDSC website, we will continue to serve as a link between consumers and the Canadian research community and as the conduit for knowledge translation.

Organizational Capacity Building

The MDSC Board plans to become more diverse and fully representative with an appropriate regional, gender and multi-cultural balance of membership. In addition to enhancing the Board, the MDSC is committed to giving active consideration to the establishment of advisory councils from diverse communities, e.g. youth, seniors, etc.

VII INTERIM PROJECT EVALUATION

The *Blueprint for National Action Evaluation Interim Evaluation Report* comments on three significant issues for MDSC as it moves forward with the Blueprint: definition of MDSC's relationships with other consumer/user groups; development of the MDSC Board and its institutional capacity, and broadening and sustaining the MDSC presence on the web. The following fourteen recommendations contained within the interim project evaluation were used to inform this planning process.

Evaluation recommendations are:

Council of the Provinces

1. Define an appropriate relationship with affiliated NGO's.

A challenge for MDSC will be maintaining its loose relationship with the varied groups of organizations participating in the Council of the Provinces and avoiding the tendency to use its central position to exert authority or control over the NGOs with which it works. This relationship, however loosely it might be defined, needs to be clarified to prevent recurring and marginally useful discussions of this issue.

2. Provide data on populations served by MDSC and other mental health NGOs.

There is some difficulty determining the percentage of the total consumer/user population in any specific region that is being served by the NGOs operating in that area, and it is also a challenge to determine the effectiveness of this service. As such, the level and quality of "coverage" being provided by MDSC directly or indirectly through provincial NGOs is a challenge to describe. One way to increase resources allocated to mental health issues is to address these difficulties.

3. Find ways to measure effectiveness of NGO services to consumers/users

Mental health NGOs' descriptions of themselves seemed focused more on their activities than on results, and while they report on the number of events held, there is little information on the impact of these services on the lives of those reached by the NGOs. Finding ways to measure the effectiveness of these services will strengthen the case for increased attention to mental health by all levels of government and the private sector. This has implications for defining issues such as accountability and return on investment for funding provided to MDSC and its associated agencies. There likely is relevant information on how to do this in other sectors such as preventive medicine and the government's HIV-AIDS program.

Scientific and Cultural Consultation

4. Establish the Scientific and Cultural Consultation as an annual event

This sort of interdisciplinary and multi-sectoral consultation should be held annually. This first event served as a bridging exercise, establishing linkages among fields of research and practice that would otherwise not know of the benefits to be acquired from others' knowledge and experience. There is much more work to be done of this nature.

5. Identify consumer/users to recommend for the Health Council of Canada

Michael Decter, the keynote speaker during the dinner following the main part of the conference, clearly indicated the new Health Council of Canada would benefit greatly from closer linkages with the consumer/user community and requested MDSC to make recommendations for members of the Council and its support group of researchers and policy analysts. MDSC should seize the opportunity and take Mr. Decter up on his invitation.

6. Establish a priority list for research and policy development

Panelists' suggestions for future initiatives would be enough to keep several NGOs, government departments and research facilities fully occupied for years. MDSC should set up and maintain a priority list for research and policy development to guide future initiatives by a variety of agencies and government departments.

7. Create the institutional capacity to share information and collaborate across sectors.

The consultation indicated a clear need to establish mechanisms to link together the various sectors working on mental health issues. MDSC should advocate for a structured means to foster this interdisciplinary and cross-sectoral collaboration on issues of common concern.

8. Find out why this was not done before and eliminate that blockage

This consultation should have happened long ago: the fact that this was the first event of its kind when it should have been obvious that this was required indicates there are other problems in the field. Somebody could have used such a forum as a foundation for policy in several government departments and possibly even legislative change: why this did not happen earlier could make for an interesting discussion. MDSC should explore the reasons for this obvious deficit in our systems and take steps to eliminate this blockage in the evolution of competent governance.

MDSC Board Strategic Planning

9. Consider including the following in a MDSC's identity statement

One of the structural challenges facing the Board is a comprehensive statement of MDSC's identity. It may want to consider adding the following to existing statements: "MDSC is a national level mental health consumer/user driven organization that acts on its own behalf while it serves and is supported by a number of national, provincial and territorial consumer/user groups. It is also a direct service provider to individual consumer/users through its web site and other activities."

10. Define MDSC’s vocabulary about its structure.

Two vocabularies are used in MDSC in describing its structure and relations with other mental health NGOs – one is the more traditional clearly-defined structure with all that it entails, the other is the looser more flexible affiliation that is part of the emerging virtual world. While some organizational concepts and practices are compatible with both, some are not. All actors need to acquire the comfort and the emergent vocabulary that is part of a new way of functioning.

11. Allow the MDSC Board's internal structure to evolve: don't rush it

The structure of the Board's relationship with the Executive Director and other MDSC employees or contractors were clearly in a state of development – roles were not clearly defined, and members said they were comfortable with that ambiguity for the time being. There was some discussion of working with a "Carver Model" to clarify roles and responsibilities, but this was not pursued in the meeting I observed. The Board should maintain its comfort with this ambiguity and allow an appropriate structure to emerge as time passes and experience accumulates.

12. Don't bite off more than you can chew

The Board has set itself an ambitious agenda with a 12-item do-list in addition to existing initiatives. There is the obvious question as to who will actually do all this work. Board members had an interest in these areas, and portfolios were assigned, but there is far more on the list than a group of volunteers can be expected to do. The Board should pace itself, and clearly define which are the more important areas and allow secondary issues to remain un-addressed while MDSC builds up its track record and acquires the institutional capacity to carry through with its already significant workload.

13. Devote significant energy to succession planning at all levels

The creative talent at the core of MDSC rests on a few shoulders, and they're not getting any younger: the Board should dedicate significant effort to building up its core leadership capacity through a concerted succession planning process.

MDSC's presence on the web

14. Find resources to adequately support your web site activity

Maintaining MDSC's web site is a specialized area of service that requires dedicated personnel with the appropriate blend of enthusiasm, awareness and skill. One of the pressing dimensions of this service is the response time to chat room comments and questions. The person posting a message sometimes is in desperate straights, and needs quick, kindly and accurate responses. This is a time consuming service that deserves to be sustained and expanded. The user community has been informed that additional assistance is needed, and as yet no one has come forward to carry part of the load. The existing way of providing this service is not sustainable: funds need to be dedicated to support this essential resource.

AREAS OF AGREEMENT

Analysis of the Council of the Provinces conference, the Scientific and Cultural Consultation, the MDSC Board Strategic Planning Session and the Project Evaluation Report shows several areas of agreement about the focus and direction for MDSC over the next few years.

All participants think that serving as **the national voice for advocacy for those with mood disorders and providing public education** are appropriate roles for MDSC. There was also a broad consensus about the important role that MDSC can play with regard to **coalition and capacity building**, both within and between sectors and in under-serviced areas. This will require clear definitions of roles and relationships between MDSC and consumer/user groups and others, for example, the scientific community. The MDSC Board is keen to focus on **national-level research from a consumer perspective**. This objective is endorsed by the evaluator, and Dr. Remi Quirion, of the Canadian Institutes for Health Research, Institute of Neuroscience, Health and Addiction, has encouraged MDSC to move in this direction. It is also clear from the proceedings and noted in the evaluation report that MDSC needs to carefully consider its priorities and focus on achievable goals. The organization must look to the issue of **Board development and organizational structure and capacity to maximize resources and outcomes**.

MDSC views itself primarily as a **virtual organization** and this would appear to be the most effective way to approach the issue of organizational development and sustainability. The evaluation emphasizes that MDSC is "a set of relationships more than a slab of concrete", which is a new and different way for an organization to structure itself and do business. The evaluator notes further that "so far it seems to be working." Most of the proposed MDSC roles and responsibilities align with MDSC's vision of itself as a virtual organization. Further refinement in its use of web-based technology will support coalition-building activities and provide MDSC with an effective forum for public education, research and knowledge translation, targeted intervention strategies, and the establishment of ad-hoc partnerships and alliances through virtual connections for specific projects.

VIII PRIORITIES FOR FUTURE DEVELOPMENT

The following MDSC priorities are based on major policy directions emerging from the Council of the Provinces, the National Scientific and Cultural Consultation, Project Evaluation recommendations and board deliberations and overarching policy decisions related to the future direction of MDSC. The following four-point policy framework will serve to guide MDSC over the months and years to come and will be driven primarily by the continued effective utilization of technology supported by sustained and meaningful partnerships and coalitions throughout Canada.

ENHANCE GOVERNANCE AND ORGANIZATIONAL CAPACITY

MDSC will continue to evolve as an innovative and highly responsive organization, which can serve as an effective national voice for mental health consumers and their families across Canada. The MSDC sees itself as a primarily virtual organization with a small, cost-effective infrastructure. The virtual nature of the organization allows it to bring people together, particularly through information technology, and to respond quickly and easily to emerging needs.

In 2004, MDSC received funding from the Office of the Voluntary Sector, Health Canada to undertake a comprehensive organizational scan and board development and training initiative. The primary objectives of this endeavour are to:

- To build upon the efforts of the Board's strategic planning initiatives including the recent Blueprint for National Action which included the Council of the Provinces and National Scientific Cultural Consultation held in Ottawa in March and April 2004.
- Examine board membership and composition to ensure national representation;
- Establish appropriate governance, staffing and operational models for MDSC with a special emphasis on developing a virtual office for the organization with a small number of full-time employees;
- Undertake board development and training to formalize and clarify board/staff roles and responsibilities;
- Develop formal policies and procedures to guide the governance and administration of the organization;
- Develop a plan for succession.

This initiative is to begin in June 2004 and be completed by January 2005.

FOCUS ON DEVELOPMENT AS A VIRTUAL NATIONAL ORGANIZATION

Priorities for future development

1. Enhance virtual capacity of the organization.

- Seek more resources for web-based activities.
- Hold more frequent board meetings as on-line discussions through the chat room.

2. Provide web-based public education and knowledge translation

- Consult with provincial and territorial groups and website users to **set priorities and develop evidence-based resources** in easy to understand and accessible language to enable Canadians to make informed health care decisions. Materials developed will be then made available for use by provincial and territorial groups.

- Building on the Board of Directors stated priorities and the recommendations of its provincial partners and its social and scientific advisors, **the focus and the content of the web site will be about providing resources on the following:**

    - Understanding and confronting the stigma of mental illness.
    - Mental health across the lifespan including the early years, children, youth and the elderly (Currently in development).
    - Employment and workplace issues and the role of the employer in creating healthy workplaces (Currently in development).
    - Addressing the Mental Health of Canada's First Nations through partnerships and collaboration.
    - Multi-culturalism and mental health.
    - Exploring the link between mental health and spirituality.

- MDSC website content will be informed through consultation with leading experts, review of the scientific research literature and will reflect the experiences of consumers and families. Included in each new content area will be **links to other organization and resources** including government websites, recommended readings and references.

- Through this process the MDSC will **develop partnerships** with professional organizations, researchers and community groups to build trust and use this influence to communicate the needs and priorities of consumers and families. The MDSC will promote its resources and seek reciprocal links to recommended websites to build a greater network of interconnected resources.

- MDSC executive staff and Board members will actively **participate in planning**, **research and consultative processes at the federal level** that are aligned with its strategic priorities. The MDSC will post on its website and through its electronic newsletter (in development) activities being undertaken by the MDSC, key messages communicated, reports of interest, new research, policy documents and information about government consultation process seeking ongoing feedback from Canadians.

- Through the use of Babel Fish, an **online translation** service, site visitors can easily translate website content into any language more directly meeting the educational needs of our multi-cultural society. Where financial resources permit, content is provided in both official languages.

3. Serve as a National Clearing House for information and resources related to mood disorders.

Priorities for future development

- **Facilitate inter-provincial sharing** of information and resources to foster the development and growth self-help. The MDSC will use this information to create evidence-based resources for distribution through provincial networks and professional organizations in the form of electronic and print brochures, fact sheets, educational and training resources.

- The MDSC will use '**best practices' and innovative approaches** in addressing mental health issues. Through its website and electronic newsletter, MDSC will highlight approaches with demonstrated efficacy in illness prevention, treatment and recovery and will strengthen the capacity of people with mental illnesses to achieve full citizenship and participation.

- Actively **supporting self-help and linking people to available resources** are key priorities of the MDSC. Where these resources do not exist the MDSC will work with the provincial and territorial groups to foster new group development.

- The MDSC will provide a **daily media and news service** through its ENews feature providing site visitors with news reports of interest on mood disorders.

- Explain the available treatment options for mood disorders and actively **link Canadians to professional services** to close the current gap in help seeking behaviour and need**.**

- Through the provision of an '**Ask the Expert'** feature, create the opportunity for site users to engage in a real-time discussion with recognized experts. These discussions are also archived on the site to create a useful resource of materials.

- Develop an **Electronic Newsletter** which will serve to inform our community of current activities, highlight 'best practices' in mental health, inform people of emerging research, provide health alerts, share new and interesting resources and promote its key messages and partnerships. (currently under development).

4. Provide a forum for the voices of consumers and families

Priorities for future development

- Through the provision of a web-based **Discussion Board**, create an electronic community bulletin board to link consumers and family members together to share information, post their questions, seek advise, support and help others in overcoming the day-to-day challenges on living with a mood disorder. This service will be built on the self-help model with volunteer leadership being recruited to facilitate the discussion forums. Through the Discussion Board the MDSC will have direct access to consumer concerns and understand the issues and concerns of Canadians to further inform its planning and policy decisions.

- The MDSC **Chat Room** creates a real-time virtual peer support group where people can come together to share their stories, concern and support. This service is currently not moderated and the MDSC will commit resources to recruit, train and support volunteers to serve as facilitators. The chat room feature also allows for free real-time discussions between the Board of Directors, provincial partners and members.

- **Evaluation** of our services is crucial to its success. The MDSC has built into its website and all the unique features an evaluative component. An exit poll allows visits to comment on their level of satisfaction with services provided. Through polling features we are also drawing information on the opinions and attitudes of our site users.

COALITION AND CAPACITY BUILDING WITHIN AND BETWEEN SECTORS

MDSC is positioned to take a lead role in building national capacity through the development of strategic coalitions within and between sectors. Based on the extensive national consultation process, the following action plan will be pursued.

Priorities for future development

- **Define an appropriate relationship with affiliated NGOs at both the national and provincial levels.** This strategy will involve extensive and meaningful consultation in defining relationships with a wide variety of like-minded NGO's across the mental health spectrum in Canada. MDSC will take a lead role in forging strategic alliances aimed at collectively dealing with major issues identified within the context of this national planning initiative such as stigma, advocacy, public education along with promoting and fostering linkages with the Canadian scientific and cultural research communities. Priorities for partnerships and coalition development will include:

    - **Aboriginal communities**. The MDSC will work on developing linkages with the Native Mental Health Association of Canada and the INMHA Aboriginal Institute with regard to spirituality and mood disorders, and other related issues. MDSC is committed to advocating for additional resources for Aboriginal mental health with a particular emphasis on rural, remote and northern communities in Canada.

- **Spirituality and Mood Disorders**. Over the past three years The Mood Disorders Society of Canada has conducted extensive research in the areas of spirituality and mood disorders from a consumer perspective while working closely with Canada's research community. The Society is now poised to take a leadership role in forging formal partnerships with the scientific, caregiver and faith communities in Canada. To this end, MDSC will be presenting a paper to the International Conference on Mental Health and Spirituality scheduled for December 6 & 7 in Ottawa on the role of NGO's in this domain of research and development. Concurrently MDSC is in the process of developing a national strategy with the scientific and faith communities throughout Canada aimed at bridging the gap between consumers and these communities.

- **Canadian Youth.** MDSC recognizes the need to engage young Canadians as equal partners in an active meaningful manner as it moves forward with its national strategic agenda. The compelling messages of Canadian youth during the National Scientific and Cultural Consultation will serve as a catalyst for MDSC to move forward in establishing strategic alliances with national organizations such as the Centre of Excellence for Youth Engagement, the Students Commission of Canada and Youth Net to develop and implement collective strategies that will engage youth in areas related to public education, eradication of stigma and advocacy. MDSC is also prepared to support the inclusion of youth in shaping and, in some instances, conducting social policy research in Canada.

- **Seniors.** Working closely with other NGO's and existing national seniors coalitions, MDSC will use its national virtual connectedness to educate the public and family members about mood disorders and the elderly and advocate for the needs of the elderly, including access to appropriate care.

- **Workplace.** Disabling mental illness is an increasingly significant social and economic concern – approximately 20% of the general population is currently effected, with the most common problems being anxiety, mood and substance abuse disorders. According to the Global Business and Economic Roundtable on Addiction and Mental Health, the costs of mental illness in the Canadian labor force – unchecked and only recently documented – exceed $33 billion a year in lost production alone. Mental illness is the leading cause of worker disability. Employees who need help to address mental health issues often find their organizations are not well equipped to respond to them. MDSC recognizes that the introduction of self-help and self-care from a consumer perspective into the Canadian workplace is very timely. Employers in the private, public and non-profit sector appear likely to embrace initiatives from a consumer perspective and to this end, MDSC will begin immediately to design and develop pilot consumer driven initiatives into the workplace. Two members of the MDSC Board of Directors with extensive experience in this area have assumed a lead role.

- **Use the web for coalition building.** The MDSC will use information technology- the chat room, electronic newsletter and resources and training to build and maintain coalitions and support coalition building activities between other like-minded organizations and within and across sectors.

LEADERSHIP ROLE - ENGAGING IN RELEVANT RESEREARCH

Priorities for future development

- MDSC will continue with its successful research initiative launched in 2003 on the relationship between disabling mood disorders (primarily depression) and pathological gambling activities (funded by the Ontario Problem Gambling Foundation).

- MDSC has recently submitted a major multi-year consumer-driven research initiative to the Department of Social Development. This project will identify barriers and facilitators to effective services and workplace inclusion from *multiple consumer perspectives,* bring together consumers and employers who are known to be leaders in promoting workplace inclusion to review these findings and use consumer knowledge and experience to *inform* employers of the characteristics of workplaces that provide access to effective services and promote and support inclusion and those that do not. It will *use the knowledge and experience of both groups* to support the development of a partnership between consumers and employers and the development of a joint, sustainable communications strategy to share project findings with Canadian employers, employees and the public in a way that will benefit all Canadians.

- MDSC will continue to take an active role and serve as a strong national voice for consumers in major Canadian research initiatives sponsored by the Canadian Institutes of Health Research and the Institute of Neurosciences of Mental Health and Addiction in areas related to workplace, stigma and children and youth.

- MDSC will work closely with the Native Mental Health Association of Canada in promoting research on healthy Aboriginal families and child and youth mental health through the Institute of Neurosciences and Mental Health.

- MDSC will define an appropriate relationship with the scientific and cultural communities in Canada and will attempt to promote annual National Scientific and Cultural Consultations on crucial issues defined in consultation with sector partners and public policy makers.

IX CONCLUSION

The MDSC capacity building initiative on mood disorders in Canada has been a tremendous success and represents the first time in Canadian history that a national planning framework has been formulated that is directly aimed at addressing major issues facing consumers and their families. The National Scientific and Cultural Consultation represents a unique and important breakthrough in the approach to policy development, which must be fostered and maintained over time.

The Board and staff of the Mood Disorders Society of Canada would like to express deep appreciation to the provincial leaders of the mood disorders movement in Canada for their meaningful contributions and leadership in representing the best interests of Canadians and also to all of the MDSC national partners.

The compelling messages from expert advisors have effectively set the stage for MDSC and its national and provincial partners to move forward and meet the many challenges that lie ahead and to be poised to seize the numerous opportunities that await us in the ensuing months and years.

Finally, MDSC would like to formally acknowledge and express sincere appreciation for the financial support and encouragement received over the past year from the Office of Disability Issues of the Department of Social Development.

APPENDIX "A"

KEYNOTE SPEAKER

Mr. Michael Decter - Chairman

Health Council of Canada

As the current Chair of the newly formed Health Council of Canada, and past Chairperson of the National Board for the Canadian Institute for Health Information, Michael Decter embodies over 25 years of experience in the public and private health sectors.

As a consultant, Michael has led major assignments for many of Canada's leading teaching hospitals. These assignments have included reengineering, mergers, and strategic planning.

Michael Decter is described as "one of the best and brightest public servants of his generation". A Harvard-trained economist, Decter is president of an investment management firm. Also a former Deputy Minister of Health for the Ontario Government, Decter now travels widely as a consultant and public speaker on managing health system reform.

EXPERT PRESENTERS

Dr. Rémi Quirion – Scientific Director

Institute of Neurosciences, Mental Health and Addiction

Douglas Hospital Research Centre

Dr. Rémi Quirion is a Full Professor and Scientific Director at the Douglas Hospital Research Centre (a McGill affiliated teaching hospital) in Montreal. Under his leadership, the Douglas Hospital Research Centre became a premier research facility in Canada in the fields of neurosciences and mental health. Dr Quirion promoted the development of clinical research in Neurology and Psychiatry as well as social and evaluation aspects of research in mental health and addiction. A member of the FRSQ Board of Directors, Dr. Quirion is also active on many other national bodies. His research interests include: understanding the relationships between key phenotypes of the Alzheimer's brain, molecular and pharmacological features of neuropeptide receptors focussing on NPY and CGRP, and their role in memory, pain and drug dependence, and models of schizophrenia. A major interest lies in the training of the next generation of scientists. In addition to being on the Advisory Board of over 15 scientific journals in Psychiatry, Pharmacology, and Neurosciences, Dr. Quirion has published 5 books and more than 500 scientific papers and articles. In 2003 he received the First National Champion of Mental Health Award (Research) in addition to the titles of the Royal Society of Canada Fellow and the Chevalier de l'Ordre national du Québec.

Barbara Jaworski – Director

WorkLife Solutions and Well Being, FGI

Barb Jaworski, Director, WorkLife Solutions and Well Being for FGI, is responsible for the implementation and evolution of what was once a child/eldercare resource to its current position as FGI's WorkLife Solutions - fourteen programs that comprise one of the most comprehensive and innovative work/life and wellness services in the industry. Barb conducts research in organizational health and has recently developed a new model of organizational health that incorporates work/life. She also writes an e-newsletter called the Manager's WorkLife Newsletter which educates managers on new research and trends in the WorkLife /EAP field. Barb additionally trains internal staff and acts as FGI's expert in WorkLife and prevention issues.

Prior to her role at FGI, she spent 15 years at the Municipality of Metro Toronto and City of Toronto, providing social work and crises services to seniors and their families, and developing housing programs and homecare standards. She received her MBA from Ivey Business School in 1996. Barb is currently a member of the Conference Board of Canada, and a member of the Alliance of WorkLife Professionals (AWLP).

She advocated for the new Compassionate Care Leave Program Benefit across Canada, which allowed 8 weeks leave for those who have a critically ill family member.
Barbara is project manager for the new Best Employers for 50 Plus Canadians Award sponsored by CARP, the Association for the Fifty Plus. She is co-chair of the Global Work life Innovation Awards given annually to organizations anywhere in the world that display innovation in creation of solutions to their people issue.

She speaks at conferences on the topics of WorkLife integration, stress, healthy organizations, global cultural issues and the aging workforce.

Dr. Catherine Shea – Vice President

Canadian Academy of Geriatric Psychiatry

Dr. Cathy Shea is Vice President of the Canadian Academy of Geriatric Psychiatry and the Chairman of the Education Committee for the Academy. She is a geriatric psychiatrist at the Royal Ottawa Hospital in Ottawa, Director of Rural Outreach for the geriatric psychiatry program and an Assistant Professor at the University of Ottawa.
Dr. Shea completed medical school and a psychiatry residency at Dalhousie University in Halifax, Nova Scotia and fellowships in Geriatric Psychiatry at the University of Ottawa and in regulatory affairs at the Therapeutic Product Division of Health Canada. She works with other mental health professionals to provide psychiatric consultations to rural seniors in community hospitals, nursing homes, retirement residences and their own homes in the counties surrounding the city of Ottawa. A typical week includes traveling 800 to 1000 km. seeing patients and providing education sessions. Education to patients, families, doctors, medical students, nurses, and caregivers about recognizing and treating mental illness in the elderly is a passion. Dr. Shea lives in Ottawa with her husband, a middle school principal. Together, they have 5 boys and a menagerie of pets.

Dr. Jordan Peterson - Professor

University of Toronto

Dr. Jordan Peterson is a clinical psychologist, licensed in Massachusetts and Ontario, and see clients on a relatively regular basis. Dr. Peterson is a professor at the University of Toronto, and has been since 1998. Before that, he was a professor at Harvard University, from 1993-1998. Dr. Peterson completed his graduate and post-doctoral work at McGill University, under the supervision of Dr. Robert O. Pihl, studying alcoholism and aggression.

Currently he is interested in the formal assessment and theoretical nature of self-deception, construing it as voluntary failure of exploration rather than as repression (although both mechanisms appear to obtain), and also does experimental work on creativity, achievement, personality, narrative and motivation. Dr. Jordan Peterson has published a book, Maps of Meaning, in 1999.

Dr. Brenda Restoule, PhD - Board of Directors

Native Mental Health Association of Canada

Dr. Brenda M. Restoule is a clinical psychologist, registered with the College of Psychologists of Ontario. She is a member of Dokis First Nation, a semi-isolated community in Northeastern Ontario. Brenda's spirit name is Waab-Zhe-Kwens (Little Swan) and she is from the Eagle Clan. She received her undergraduate training at the University of Western Ontario in London, Ontario and her graduate training from Queen's University in Kingston, Ontario. She has worked with Aboriginal people in a variety of capacities and settings. She was the Aboriginal counsellor in the psychology department at the Kingston Prison for Women for 4 years prior to its closure. She was also involved in a research capacity studying cultural identity as part of the Royal Commission for Aboriginal Peoples. Cultural identity and health status of Ojibway people was also the main components of her Master's and Doctoral level dissertations. She has worked with children and families at the Regional Children's Psychiatric Centre in Sudbury, Ontario providing psychological assessments, interventions and evaluations. She was also a clinical consultant to Cedar Lodge, a sexual abuse-healing lodge, for approximately 3 years. Brenda presently works for the Native Services division of the Northeast Mental Health Centre in Sudbury, Ontario. She provides psychological consultation to 3 First Nation communities (Wikwemikong, Nipissing and Whitefish Lake First Nations) where she provides direct counselling to individuals, groups & families; workshops on various mental health issues; psychological assessments; consultation to front-line workers regarding clinical issues; and program and community development. She has also held the position of Ontario representative and treasurer on the board of the Native Mental Health Association for the past 7 years. She has offered a variety of workshops to different groups in her territory and consults on issues affecting mental health and wellness of First Nation peoples. Brenda has a strong commitment to utilizing western and traditional approaches to healing to promote wellness in First Nation communities.

Pytor Hodgson

Centre of Excellence for Youth Engagement /
Students Commission of Canada

Born into the Child Welfare system in Toronto, Ontario in 1974, Pytor has been active in supporting other youth in/from care, custody, on the street, youth diagnosed with mood disorders and other marginalized youth for over ten years.

Through foster care, adoption, group care and years involved with street culture, 17 year old Pytor helped found the Ottawa-Carleton Homeless Coalition, a street shelter for homeless youth, camped out on the sidewalk of Parliament Hill. At 19 Pytor settled in Calgary and began working as a live in peer counsellor with a youth shelter. Pytor then became the executive director of the Alberta Youth In Care Network, a youth run organization that provides a voice for youth living in care.

Since 1999 Pytor has been with the Students Commission and Centre of Excellence for Youth Engagement examining and identifying why and how the engagement of young people saves lives, using his experience as an example.

In this time Pytor has been working as a direct support to young people with mood disorders across Canada; helping them in accessing supports, services and then become active agents and stakeholders in their own treatment and care.

This commitment to youth and youth helping youth initiatives has made Pytor a sought out commentator on the issues that are facing young people. He served as President of the National Youth In Care Network and acted as an advisor to many government and non-profit organizations. Pytor has spoken in over 1000 settings including workshops, panels, plenary and keynote sessions to various audiences and highlighted over 350 times by the media.

After surviving abuse, depression, the street, chronic drug addiction, and the child sex trade Pytor is a dictionary definition of resiliency. Pytor is committed to helping stakeholders create solutions and develop new and creative initiatives that will encourage and foster a sense of partnership between youth, service providers and decision makers.

MOOD DISORDERS SOCIETY OF CANADA
BOARD OF DIRECTORS

Mr. Philip Upshall - President & National Executive Director

Mood Disorders Society of Canada

Phil Upshall is currently the President and the National Executive Director of the MDSC. In 1991 Mr. Upshall was diagnosed with bipolar affective disorder. Mr. Upshall is also the National Executive Director of The Canadian Alliance on Mental Illness and Mental Health (CAMIMH) which organization is one of the major sources of information and advocacy on mental illness and mental health in Canada.

Phil is currently a member of many committees, including the National Working Committee on the Use of Placebos in Clinical Trials Involving Human Subjects; the Institute Advisory Board for the Institute of Neurosciences, Mental Health and Addiction of the Canadian Institute of Health Research and the National Collaborative Mental Health Care Project Steering Committee under the Primary Health Care Transition Fund.

Phil is also an adjunct profession in the Faculty of Medicine, Department of Psychiatry at Dalhousie University.

Bill Ashdown – Vice President

Mood Disorders Society of Canada

Bill Ashdown, was diagnosed with severe depression and bipolar disorder at the start of his business career. Mr. Ashdown is currently the Vice-President of the Mood Disorders Society of Canada. Mr. Ashdown is also the Chairman of the Board of the Depression and Bipolar Support Alliance of the United States. This organization, the largest of its kind in the world, includes over 1,000 support groups and chapters, across ten nations.

Mr. Ashdown serves on a number of advisory boards in both Canada and the United States. He is a founding member of the Canadian Alliance for Mental Illness and Mental Health (CAMIMH), one of the strongest voices for mental health in Canada.

Based in Winnipeg, Mr. Ashdown divides his time between public speaking throughout North America, and working in the development of organizations for people with mood disorders.

John Starzynski - Secretary-Treasurer
Mood Disorders Society of Canada

John is currently the Secretary-Treasurer of the MDSC. John also serves as the Volunteer Executive Director of the Ontario Bar Assistance Program working closely with lawyers who suffer from challenges with mental health issues, stress, burnout or addictions. John has received training through the American Bar Association Commission on Lawyers Assistance Programs. John is certified through the Addiction Intervention Association as an Associate Counsellor for Alcohol and Drugs. John practiced matrimonial law and litigation until 1990 when he stopped practicing due to his continuing experience with depressive illness.

John has been married to Marg for 29 years and they have two sons. John and his wife reside in Guelph, Ontario.

Chris Summerville – Board Member
Mood Disorders Society of Canada

Christopher Laine Summerville (Chris), B.A., M.Div., M. Miss., D. Min. CPRP, (C.P.E). Chris grew up in Birmingham, Alabama and has lived and worked in Canada, with dual citizenship, for the last 20 years. Married to Carolyn Thomson, they have one daughter, Lydia. Their home is in Steinbach, Manitoba.

Since 1995 Chris has been the Executive Director of the Manitoba Schizophrenia Society, Inc. giving leadership and supervision to 18 staff located in the home office in Winnipeg and the eight regional outreach offices in Manitoba. Manitoba Schizophrenia Society is a non-profit, community-based, mental health registered charity formed in 1979, providing support and services free of charge to those experiencing the impacts of schizophrenia. MSS is innovative among the schizophrenia movement in Canada. Though it is part of a “family” national organization, the Schizophrenia Society of Canada, MSS is “consumer focused and family sensitive”, holding to a holistic perspective: bio-psycho-social-recovery-spiritual-empowerment model. The majority of the Board of Directors and employees are consumers.

Tracey Lynn Trudeau – Board Member
Mood Disorders Society of Canada

Tracey began her work in the mood disorders field with the Mood Disorders Association of Manitoba with a focus on outreach, education, and advocacy. While at MDAM, Tracey developed a system of paraprofessional screening of mood disorders in partnership with rural practice physicians, introduced at the 49th annual meeting of the Canadian Psychiatric Association. Tracey attended the University of Manitoba and was the recipient of the U of M Graduate Fellowship Award for highest academic standing and research excellence, and the University of Manitoba Student Union Scholarship. After completing her training as a school psychologist, her interest began to focus more closely on the impact of mood disorders and other psychiatric illnesses upon children. Tracey has an ongoing interest in research and conducted one of only a handful of studies on the impact of bipolar disorder on education of children, titled "*Transition of Bipolar Students From Hospital to School*" (2nd *European Stanley Foundation Conference on Bipolar Disorder, Amsterdam*).

In 2000 Tracey was recruited by the Alberta Government to be part of a pilot initiative (Student Health Initiative Partnership) that targets complete health services to students with a focus on early intervention for mild and moderate needs. Working within the department of Emotional Behavioural Services, Tracey's time is divided between school-based individual and group psychotherapy, consulting with teachers and special education staff, educating parents, and lecturing. Most recently, Tracey conducted a pilot treatment group for high school students with severe test anxiety, delivered on-site and in conjunction with the school counsellor.

William J. Mussell – Board Member
Mood Disorders Society of Canada

Bill has over 40 years of experience working as a professional in probation and parole, adult education, college and university instruction, and senior management including Executive Director of the Union of B.C. Indian Chiefs, founding chair of the Coqualeetza Cultural-Education Centre, co-founder of the Sal'i'shan Institute and its current Manager and Principal Educator, and President and Chair of the Native Mental Health Association of Canada. His main academic teaching has been with U.B.C., Capilano College, Simon Fraser University, the Institute of Indigenous Government, and the Sal'i'shan Institute that gives priority to healing and personal and professional development in fields of health/mental health, addictions, and family education. His research experience has focused primarily upon Aboriginal social development, education, health, management and mental health issues. Bill also has 45 years of experience doing volunteer work, including service on the executive of the North American Indian Brotherhood, treasurer and chair of the Vancouver Indian Friendship Centre, administrator, planner and chief of the Skwah Indian Band, member of founding board for the University College of the Fraser Valley, governor of the Fraser East Health Board, and other similar roles addressing legal and justice matters. Bill is a member of the Skwah Band at Chilliwack Landing (Sto:lo territory). He was the first of his community to graduate from high school, and the first of his cultural territory to graduate from university. Bill is married and has two daughters. His wife Marion, an Oneida, works with him filling roles and responsibilities connected with the Sal'I'shan Institute and the Native Mental Health Association of Canada. They work out of their home situated next to the home base of his late parents.

"This project is funded by the Government of Canada's Social Development Partnerships Program"

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