



In conversation with

Louise Bradley

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Ken Tremblay

In 2006, a Standing Senate Committee completed Canada's first national study of mental health - **Out of the Shadows at Last – Transforming Mental Health, Mental Illness and Addiction in Canada**. It chronicled this country's challenges, efforts and gaps in meeting the needs of Canadians suffering with a suite of mental health conditions spanning health, justice, housing, primary care, employment and families. Created the following year with Senator Michael Kirby as its inaugural Chair, the Mental Health Commission of Canada (MHCC) became the national sponsor for mental health issues. Funded by Health Canada with a mandate that will take into the late 2020s, the Commission is not responsible for service delivery or advocacy; rather, its aim is to provide relevant jurisdictions and stakeholders with the tools and information required to improve the quality and access of mental healthcare across Canada. Leading that charge is President and CEO Louise Bradley, a healthcare executive whose nursing roots in Newfoundland paved the way to senior leadership roles in community hospitals, academic centres and regional health authorities. With an undergraduate degree

from Dalhousie and a Master of Science from Northeastern, Boston, and active in teaching, governance, nursing, leadership and Accreditation Canada, Louise received the Queen's Diamond Jubilee Medal in 2012 for her outstanding contributions in mental health and the 2015 Innovation Award from the Canadian College of Health Leaders in recognition of her leadership in mental health in Canada. HQ's Ken Tremblay spoke with her this fall.

HQ: Seems like we have the right person leading the charge to change the landscape of mental health in this country. From service provider, to hospital and health authority leadership to "commissioner" on a national stage: how would you describe that journey?

LB: It's been an exciting and fortuitous journey. I've been involved with mental health since nursing school in the late seventies. I left mental health for a couple of years when I was at the University of Alberta Hospital in Edmonton, a large

tertiary care facility. I remember a day when some surgeons about a colleague who had taken a leave because of mental health problems and that I was quite surprised at some of their comments. One asked: “You came from mental health, didn’t you? Do you miss it?” And I replied: “What makes you think I ever left because I use my skills as much or more here than I ever did in any mental health setting.” It was a very interesting couple of years and I loved the work. But when the commission’s recruiter called, I realized it was my real passion. So I came back to it quite openly and honestly.

HQ: All Federal parties voted in favour of the creation of the MHCC and provincial and territorial governments concurred, with the exception of Quebec, demonstrating one of the challenges of a national organization. How does the MHCC model help “herd the cats” given such federal – provincial tensions around jurisdiction and funding?

LB: It’s not an easy thing to manoeuvre, I can tell you that! I have unique relationships with 14 different provincial and territorial governments, and, of course, the federal government because of [that] jurisdictional divide. We have a couple of pieces that help us with that. The original provincial and territorial advisory council to advise us on the creation of the national strategy is still in place and they meet on a regular basis. It’s been hinted that they like what we are doing in terms of the relationships we have among the provinces, territories and the Federal and it’s a role I’m quite happy to play. The federal government is responsible for a large group when it comes to our ability to have an impact on national [mental health] strategy; we have to rely on the provinces and territories to carry that out. It’s important that we have a close relationship with them.

HQ: How does MHCC measure its success? What process indicators and outcomes are central to its role and any assessment of its effectiveness?

LB: It’s not an easy thing to measure. As an example, we like to think that there has been a reduction in stigma and discrimination. Hardly a day goes by where there’s not some mention in the media somewhere about stigma and mental illness. But is that a true marker? I still hear horror stories of people being treated unfairly and being afraid to talk about mental illness in the workplace.

When we released [national] mental health indicators, which were developed for the first time in the country, we looked at the suicide rate. The good news is that it hasn’t increased in ten years; the bad news is that it hasn’t decreased in ten years. Is that a fair marker of the success of the commission? I think so and because our shelf life is for another 12 years, it will be something

we need to focus on. Think of mental illness as a terminal illness where over 5,000 people die by suicide every year. I think we are making a difference but still have much to do. People tell me that we are but it’s really difficult to create clear markers to definitively tell us that.

HQ: Part of sponsoring significant change is about compelling stories and personal journeys, a feature that factors into using celebrities to reduce mental health’s stigma and to engage the public. How are these conversations changing the landscape of mental health here and beyond?

LB: I see Bell’s Let’s Talk Day as an amazing success. Clara Hughes has made it okay for people to look at someone, like Clara, and say “Well, if she has had a problem and she’s able to talk about it, maybe it’s okay for me too.” Michael Landsberg, Shelagh Rogers, Robb Nash, just to mention a few, are really contributing to the thought that if these really great people, who we look up to and admire, can talk about not being able to get out of bed in the morning because of their struggle with severe, depression, it sets the tone for others. It is important and we’re seeing others, including CEOs, talk about their own struggle with mental illness. That more of us have stories to tell is having a dramatic impact.

HQ: Why a “commission” structure? What advantages does that sponsorship model have versus others that are out there, for example networks, associations or alliances?

LB: The MHCC is a unique organization and we are seen as a thought leader in this area. Because we have had and still have a shelf life makes us different from other [mental health] organizations. Although the government funds us, we operate at arm’s length from it, making us further unique. We’re probably not a commission in the true sense of the word but “commission” does denote that we have a specific mandate and, by working with stakeholders and others, a catalytic focus not held by other organizations.

When you look at mental health organizations that have operated for decades, they haven’t done what the commission has been able to do, i.e., bringing people together to get the message out about [mental health] stigma. Maybe some other design would’ve worked better but, for whatever reason, it seems to work. We’re hosting an international conference this year in Vancouver where nine countries are coming together and, despite my doubts, international colleagues see Canada as a leader in mental health. We know we have a long way to go but we don’t see ourselves that way; for whatever reason, the commission has facilitated that.

HQ: In 2012, Canada became the last of the G8 nations to create a mental health strategy when we released “*Changing Directions, Changing Lives: The Mental Health Strategy for Canada*” with six strategic aims for the country. How are we doing: are we catching up and what lessons can we learn from other jurisdictions?

LB: That is something that we are looking at right now within the commission. It took us four years to write that strategy and it included the voices of literally thousands of Canadians. I'm not sure that it's all that different than if 25 of us sat down and wrote it, but it was important to hear what people had to say and the voices of lived experiences resonate throughout that document. We are now in the process of developing a mental health action plan for Canada. We have a strategy, now what does it take?

We're looking to each of the provinces and, while we don't have a report card for them, we are sharing some data so we will be able to determine an action plan and activities that will allow us to push our strategy forward. I do not want this to be a beautiful document that sits on a shelf and collects dust; it needs to be action oriented. We're taking that next step to create a mental health action plan that will make a difference.

HQ: Strategies to engage providers, professions and policy makers have their challenges. How has the MHCC shaped those conversations? Any surprises?

LB: I'm not sure if there have been surprises as much as frustrations. During a speech in PEI, you heard me share one of my big frustrations: funding. Other international leaders in mental health acknowledge that Canada is a leader and yet, compared to all the developed countries, we're spending the least on mental health. After that talk in PEI to Canada's health leaders, several said afterwards: “I'm going to go back and I'm going to do something.” I'm not sure that is happening and I've got to try and find a way of reconnecting to see if they have done something.

Mental health is a governmental issue, a private-sector issue, and it cuts across other departments: education, justice, housing. It's everywhere and everybody agrees. But when it comes to actually sitting down and penning budgets to reflect an increase in mental health spending, whether government or health authority, I don't see it. It's very frustrating. In the next phase of the commission and of my work, if we are really going to make a difference, we need to see an increase from that seven percent of health spending on mental health.

HQ: Program funding is the sharp point where individual CEOs may not have the latitude or authority

to unilaterally shift resources to mental health from other programs and mandates (given accountability agreements, etc.). How might that change?

LB: I'm not sure I agree with that comment. There is flexibility in CEO's budgets within health authorities and even a small change can have dramatic impact. As an example, it's hard to look after other people when we don't look after our own mental health. My hat is off to the health authorities that have taken charge and are implementing the psychological safety standard in the workplace for their own employees. Even without changing the bottom line there are things like that that can really have a dramatic impact in looking after our own health human resources. The healthier we are, the better able we are to care for others. When there are work plans within a health facility, we can ensure that mental health has a line item in there, however small it may be. We have to start somewhere. I have seen some creative things happen to address issues of mental health in the healthcare system.

When I was in Nova Scotia there was protected funding for mental health; you could not use mental health funds to buy a robot for the OR. It had to be used on mental health. I don't expect a sea change overnight and suddenly we're spending two percent more on mental health. But, CEOs are uniquely placed to be able to raise awareness, address mental health issues and can start with their own workforce.

HQ: Successful disease management, particularly at the population health level, requires robust health information; however, many metrics in mental health span several jurisdictions. How do you assemble and integrate the data you need to advance MHCC's mandate?

LB: If I knew the answer to that I'd probably be a very popular person. Trying to break down siloes, to get people beyond their own neck of the woods and to be mindful and caring about the bigger picture is not an easy thing to do. I've seen that in my own career where I've had to practically beg, borrow or steal money for mental health. Statistics and data, as good or bad as they may be, show that there's an impact between many diseases. For example, there's such a crossover between heart disease and mental illness, we don't know which comes first, the heart attack or the depression. It's really difficult to get people to look at the big picture and to tear down those siloes and say: “I'm going to do this because it will help in the long run.” Maybe because funding is so tight we tend to look at our little pot of sand in terms of what we can do with it instead of throwing it into the sandbox with everybody else's. We have to find new ways of doing what needs to be done.

HQ: Central to any discussion about mental health is one about youth? How does a national organization engage and drill down to that demographic in order to affect change?

LB: We engage regularly with our Youth Advisory Council to make sure we are hearing about the needs of youth living in all areas of Canada. We integrate those perspectives into our work and rely on Youth Council members to provide the youth voice in national conversations on mental health and changes to the mental health policy landscape. In order to focus on particularly vulnerable populations within the child and youth mental health landscape, over the last couple of years, the MHCC's Knowledge Exchange Centre has been working with a research team from the Children's Hospital of Eastern Ontario to produce *Taking the Next Step Forward: Building a Responsive Mental Health and Addictions System for Emerging Adults* which details the current state of policies and practices in the area of youth transitioning to adult mental health services. Youth who are engaged in child and youth mental health services are often not well supported as they prepare to enter the adult mental health system.

HQ: Of national concern are the special challenges facing First Nations, Métis and Inuit. How is the MHCC shaping those journeys, outcomes and lives?

LB: We need to do more and better, I'd be the first to admit that. In our own defence, while we have produced a lot of material, the MHCC has only been in existence for eight years.

We have had an advisory committee on First Nations/Inuit/Métis and we've acknowledged that that's an important part [of our mandate]. For an example, our Mental Health First Aid Program has been adapted for First Nations and we are currently working on one for Inuit. Suicide prevention is going to be a key focus in our strategy: it is a priority area and part of our action plan going forward. It's a very complex issue, there's no question about it. And it's something that concerns me.

HQ: Any sense of what you want your legacy to be at the MHCC? What could be the art of the possible when it comes to mental health in Canada?

LB: I've been asked that question before and I find it amazingly egotistical. I'm not somebody that looks at my own legacy. I'd like to think that I've contributed to and not taken away from the changes that are taking place, and I will continue to do that. If there was one thing that I would really love to see: we have got to see a decrease in suicides in Canada. I lost my very best friend to suicide; I know the impact that that can have, even years later, on so many people. It's one of the great tragedies of mental illness. There is so much suffering and yet people feel ashamed to talk about it. If we can really attack that stigma, we will see a decrease. To have senseless deaths due to mental illness has got to be one of the great tragedies in this day and age. If I can live long enough to see an amazing reduction in suicides, we'll have done well.

HQ: Thank you. HQ

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