# The Path to National Mental Health Policy in Canada

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For over a decade, I had the privilege of working with thousands of people from across the country on developing mental health policy for Canada. In what follows, I concentrate on a number of strategic issues that confronted attempts to set out mental health policy at a national level, and draw a few conclusions about the successes and limitations of this enterprise. The bulk of the discussion concerns four issues:

1. The relationship between the Mental Health Commission and the development of a Mental Health Strategy for Canada.
2. Using a recovery approach as the philosophical foundation for the Strategy.
3. The Mental Health Strategy as an exercise in balance.
4. Speculation on a couple of alternative paths that were never explored.

I begin, however, with a bit of personal and contextual background, and conclude with a few thoughts on what needs to be done today.

**Background**

My initial engagement with mental health policy was as the research director and lead author of *Out of the Shadows at Last*, the first national review of mental health issues conducted from 2003–2006 by the Senate Standing Committee on Social Affairs, Science and Technology led by the then senator, Michael Kirby. When, in response to *Out of the Shadows*, the Mental Health Commission of Canada (MHCC) was created in 2007, I became its first employee and joined Kirby in helping to establish the Commission. I subsequently took on the lead role in fulfilling one of the key elements of its mandate, the development of a national mental health strategy. Over the course of the next eight years, I was the lead (or co-lead[1]) on the two documents that comprise Canada's mental health strategy, *Toward Recovery and Well-Being* (2009) and *Changing Directions, Changing Lives* (2012). I also led the development of a follow-up manual, the *Guidelines for Recovery-Oriented Practice* (2015). After the release of the *Guidelines* I retired from the Commission but (in full disclosure) have done a bit of work for it on contract since then.

The chronology, however, does not convey the accidental nature of my journey. I did not come to mental health policy work as the result of a career choice or because of personal considerations. My academic background is in political philosophy and it is only because I failed to secure university employment that I

1 I shared the leadership for the development of *Changing Directions, Changing Lives* with my colleague, Mary Bartram.

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took up a position at the research service of the Library of Parliament in 2000. Once there I was assigned to provide support to Kirby's committee because I happened to be the research analyst available. After the Committee concluded its multi-year study of Medicare that it conducted in parallel to the Romanow Royal Commission, it decided—to my disappointment at the time—to examine mental health, mental illness, and addictions.[2]

As Kirby has often observed, the choice made by the Senate Committee was driven in good part by its members' own encounters with mental health problems either directly or as family. So an initial interest in a long-neglected policy area was very much sharpened by this lived experience, and for many Committee members (most notably Kirby himself) the commitment to mental health became a cause to be championed and not just a study to be completed. Over time, as I became immersed in the multiple dimensions of the mental health equation, I came to share this commitment.

While it has now been over a decade since the publication of *Out of the Shadows*, its impact should not be underestimated, even though the federal government enacted exactly one recommendation out of the 118 the report presented. That recommendation was, of course, to create the Mental Health Commission of Canada. Its inclusion in the report was carefully thought out. Kirby understood better than anyone that a Senate Committee report, no matter how well crafted, would have a limited shelf life unless there was an institutional mechanism to champion its recommendations.

*Out of the Shadows* should be acknowledged for several other reasons. As the first national study of its kind, it played a pivotal role in, as its name suggests, bringing mental health and mental illness onto the main stage of health policy debate. It was not only the seriousness and the thoroughness of the report that contributed to its impact, but also Kirby and the Committee's insistence on listening to, reporting, and supporting the conclusions of the voices of "lived experience," both of people living with mental health problems and illnesses as well as their families. The power of the testimony gathered by the Committee over several years of public hearings was showcased in the opening chapters of *Out of the Shadows* to great effect, and the perspectives people with lived experience brought were consistently incorporated in its recommendations.

Nor should it be forgotten that the Committee also presented a comprehensive plan for bringing federal fiscal resources to bear on improving mental health outcomes with its proposal to create a half billion dollar per year federal transition fund. Let me note in passing that this recommendation remains highly relevant in the context of contemporary Federal/Provincial/Territorial (F/P/T) negotiations on health spending. The Senate Committee had, in fact, traced out a plausible plan for how to enable federal transfers to be targeted towards mental health programs run by the provinces and territories (P/Ts). There is no reason to think that this plan would no longer be feasible.

As well, the report played a role in strengthening the collective voice of the mental health community in health policy discussions and in galvanizing activity to grow and sustain public awareness of mental health issues. Finally, by calling for "Recovery" to be placed at the centre of mental health reform *Out of*

2 Although a study of addictions was part of its mandate, the Committee never really managed to tackle the issues related to substance use in any depth, and noted as much in the report.

*the Shadows* laid the groundwork for the guiding approach to mental health and mental illness that would subsequently be applied across all the elements of the mental health strategy.

**The Strategy and the MHCC**

The story of the Strategy[3] cannot be separated from the story of the MHCC. As we have seen, the MHCC was the brainchild of Michael Kirby. Kirby saw the MHCC as one component of a strategy for change. The Commission was to provide the analyses and the policy proposals that would guide the transformation of the system. But in order for these policies to be implemented, he believed that a broader social movement was required to place and sustain pressure on governments to act in the area of mental health.

He also recognized that the Commission needed to be "national" and not merely an appendage of the federal government, since it is the P/Ts that have the constitutional responsibility for the delivery and organization of healthcare services to most of the Canadian population. Influencing the P/Ts' mental health policy required persuasion, and having direct P/Ts' participation in the Commission and in the development of the Strategy meant there was a channel for achieving this.

In order to be "national," however, the Commission had to operate at arms' length from all levels of government. To be beholden to one level of government would compromise its ability to speak to them all. But while the Commission's arms' length status gave it the autonomy to freely craft policy, it also denied the Commission the authority to be able to implement that policy. The absence of either carrots (money) or sticks (legislative authority) meant that the Commission did not have any direct levers to enforce implementation.

This meant that policy documents needed to be written in such a way as to enable the vast majority of the mental health community, from government to the grassroots, to endorse them—a daunting task given the complexity of the issues and the diversity of the mental health community. Engagement had to generate a document in which stakeholders (or at least the majority of them) could "see themselves." The task of drafting the Strategy also had to be linked to the work of fostering its implementation. We hypothesized that engaging the mental health community in the development of the Strategy would not only supply the necessary input to the document, but would also encourage the community's buy-in to the Strategy's recommendations, which was an essential first step to implementation.

The continuity between *Out of the Shadows* and the work of the Commission meant that we benefitted from a spirit of goodwill when we began the process. Moreover, from the start the MHCC had incorporated a strong connection to the mental health community in its very structure. The backbone of this connection was

3 As noted, the Strategy is in fact two documents developed over two phases. The first phase, completed in November 2009 with the release of *Towards Recovery and Well-Being*, sketched the vision for what we hoped to achieve. The second concluded in 2012 with the publication of 109 recommendations on how to get there (*Changing Directions, Changing Lives, the Mental Health Strategy for Canada*). However, the Strategy also drew on many other strands of policy work conducted by the Commission, including: the *Issues and Options* paper for addressing diversity (2009); the *Evergreen Child and Youth Mental Health Framework for Canada* (2010); the *Guidelines for Seniors' Mental Health Services* (2011); the *Family Caregiver Guidelines* (2013), and the *Peer Support Guidelines* (2013). Additionally, *Turning the Key* (2013) highlighted the need for housing and supports for Canadians living with mental illness. These documents were mainly produced or initiated under the auspices of the MHCC's advisory committees that existed for the first five years of the Commission's existence and provided policy guidance that sought to be closer to the ground than the Strategy itself. As well, the work of *At Home/Chez Soi* was conducted in parallel to the Strategy, using a recovery-based approach to housing for people living with mental health problems who were also homeless.

the system of advisory committees (ACs) that the Commission created (in keeping with the design outlined in *Out of the Shadows*).[4] The relationship between the ACs, which comprised volunteers from across the country with a great diversity of expertise, and the Commission was not always smooth. Still, with respect to the Strategy the ACs were key to ensuring that it reflected community concerns and they greatly helped to shape the Strategy's vision for reform in ways that increased its chances of being embraced by the vast majority of mental health stakeholders.

The ACs' contributions were supplemented by extensive input and collaboration from the entire mental health community. The voices of lived experience were heard and were always represented inside the writing teams. Bridges were built to minority and Indigenous communities. Using a genuinely Canadian version of recovery as a guide, the Strategy was given a coherent shape by the team at the Commission. When the Strategy was published in 2012, there were no dissenting or critical opinions expressed by either government or the grassroots.[5]

Once the Strategy was released, the issue of implementation loomed large, and decisions had to be made about Kirby's original strategic plan. If he were correct that sustained public pressure was required to have the Strategy implemented and to spur government action in the mental health arena, the Commission needed to figure out how to create a "social movement" that was separate from the Commission but supportive of its policy recommendations. There had been several attempts to build the infrastructure for such a movement within the Commission, but these proved unsuccessful.

In fact, around the time the Strategy was completed, a shift occurred both in the way the Commission saw its role as a national mental health body and in the way it organized itself. A number of interconnected things happened that ultimately contributed to the Commission moving away from the Kirby strategy:

- While the Commission committed to aligning its own work with the recommendations of the Strategy, it also adopted the position that it was not responsible for the overall implementation of the Strategy.
- The Commission articulated a strategic objective to become a "trusted adviser" to government on mental health issues (and in particular to the federal government of Stephen Harper).
- The task of creating a "social movement" that had begun inside the Commission was devolved to a separate organization (Partners for Mental Health) whose links to the Commission frayed fairly quickly and eventually dissolved in acrimony.
- The eight original advisory committees were disbanded and replaced by a single Advisory Council.
- The Commission placed less emphasis on generating new policy in order to focus more on the dissemination of knowledge already created.

The combined effect of these various shifts in focus and emphasis was to make the connection between the MHCC and the mental health community considerably less "organic" than it had been, and ultimately

4 The eight advisory committees created when the MHCC was formed were: Child and Youth; Family Caregivers; First Nations, Inuit and Métis; Mental Health and the Law; Science; Seniors; Service Systems; and Workforce.

5 I knew we had largely succeeded in achieving the desired balance when I watched a panel assembled by TVO's Steve Paikin just after the release of the Strategy. At one point Paikin remarked that despite having recruited to the panel people who had previously been critical of the Commission's work no one seemed to have any serious complaints about the Strategy.

to render the original Kirby strategy for the Commission inoperable. Unfortunately no alternative approach to fostering the implementation of the Strategy was ever articulated. Different ways of championing the Strategy were discussed, but nothing with any profile was done by the Commission until the release of an Action Plan in 2016, four years after the publication of the Strategy.[6]

In some respects, the absence of a clear approach to implementation merely reflected the fact that the Commission did not have the levers to ensure implementation. Nonetheless, I think it is fair to say that over the five years since the Strategy was released it has never really captured the public's attention or found its way explicitly onto government agendas. In the section "Roads Not Taken," I discuss a couple of alternative scenarios that could have been considered. But first I turn to issues relating to the substance of the Strategy.

**Making Recovery Central**

On the content side, there are numerous themes that traverse the entire Strategy. Some of these are overarching ones, such as understanding the implications of the biopsychosocial nature of mental health and mental illness, the need to respect lived experience and respect human rights, and the importance of addressing diversity. But the theme that stands out as providing the unifying thread for the entire Strategy is the one bequeathed to it by *Out of the Shadows*: putting recovery at the centre of mental health reform.

Fewer people embraced recovery when work on the Strategy began in 2008 than do now, and many objections were raised to taking recovery as a guiding approach. In fact, the debate over recovery, both within the Commission "family" and more broadly with the mental health community was amongst the most difficult we had to navigate. Concerns were expressed that related to the ways in which recovery was understood or interpreted, as well as to the perceived consequences of implementing a recovery orientation. Some of these concerns are described in the *Guidelines to Recovery-Oriented Practice*, and include:

- A focus on the individual nature of a person's recovery journey would lead to less attention being paid to the broader social factors that influence mental health.
- The spectrum of mental health problems and illnesses to which recovery is applicable was not clear.
- The relevance of a recovery orientation to children, youth, and seniors was not established.
- A recovery orientation implied the wholesale rejection of existing practices in the mental health field; for example, the use of psychopharmacology or involuntary treatment.

It was essential that the Strategy's version of recovery respond to these (and other) concerns and much effort was expended in discussing how to develop an approach that would be acceptable. The end result was a "Canadianized" version of recovery that informed and guided every aspect of the Strategy. It emphasized that the underlying principles and philosophy of a recovery approach were applicable to all providers of mental health services, despite the many different settings, the various types of mental health problems

6 *Advancing the Mental Health Strategy for Canada: A Framework for Action (2017–2022)* was released by the Commission in 2016. However, I am not sure how the Action Plan relates to the priorities established by the Commission for its work under the current two-year extension to its funding.

being addressed, and the tremendous diversity of the population.[7] Some of the key "underlying principles" it articulated were

- believing in the possibility of recovery (hope);
- respecting people's dignity and upholding their rights;
- acknowledging the social, as well as the individual, component of mental health and well-being; and
- understanding, respecting, and celebrating the diversity of individuals and communities.

This approach to recovery was most fully fleshed out in the *Guidelines to Recovery-Oriented Practice*, a document that in many ways constitutes a third volume of the mental health strategy. It extends and expands the socially aware approach to recovery originally articulated in *Towards Recovery and Well-Being*. While many of the objectives for recovery-oriented practice it outlines remain aspirational, there are signs that recovery-oriented thinking has made important inroads in the Canadian mental health system. The Strategy's embrace of recovery has no doubt contributed to this trend.

Moreover, I would argue that the core values and principles of the recovery orientation that underpins the Strategy reflect the broad aspirations we share as Canadians for a fair, respectful society that nurtures the best in each of us regardless of background. In this regard, let me note in particular the contribution made to the *Guidelines* by organizations representing Canada's Indigenous peoples. The *Guidelines* affirm that there is "common ground between recovery principles and shared Indigenous understandings of wellness [that could provide] many rich opportunities for learning and for strengthening mental health policy and practice."[8] Many of these shared Indigenous understandings of wellness, such as promoting self-determination and dignity, adopting a holistic and strengths-based approach, fostering hope and purpose, and sustaining meaningful relationships, are also the foundation of a recovery orientation.

There is no guarantee that this potential for dialogue and mutual learning will occur, and as the *Guidelines* note, it will require that mental health practitioners understand how recovery for Indigenous peoples is uniquely shaped by Canada's history of colonization. Nonetheless, it is encouraging that this potential was recognized by the Indigenous organizations that engaged with the Commission in drafting the *Guidelines*.

**Finding the Right Balance**

Of course, the development and promotion of a Canadian approach to recovery was not the only significant feature of the mental health strategy. Recovery provided a coherent framework in which to understand the nature of mental health and mental illness and it shaped all of the Strategy's recommendations. But these recommendations also had to be both comprehensive and balanced, and they needed to be feasible while still pushing the system towards much-needed transformation. At the same time, no one group or interest—other than the best interests of Canadians' mental health and well-being—could be seen to dominate. Balance was

7 We understood diversity in a very broad sense to include the many individual and group needs—as well as the disparities—that can arise from: First Nations, Inuit, or Métis identity; ethno-cultural background, experience of racism, and migration history; stage of life; language spoken; sex, gender, and sexual orientation; geographical location; different abilities; socio-economic status; spiritual or religious beliefs.

8 *Guidelines*, p. 67.

required. Achieving this balance was our responsibility as a team.[9] Listening to stakeholders provided the raw material, but this needed to be distilled and organized into a coherent and feasible set of recommendations.

Michael Kirby encouraged us to strive for two things. First, to present recommendations that were just "inside the outer edge of political feasibility," that is, to push the system as far as we could without jeopardizing the ability of government to implement our recommendations. Second, he cautioned us not to try for an unachievable level of consensus, which he framed as his "principle of equalized unhappiness." His idea was that, even if nobody bought into 100% of a report's recommendations, it could still be embraced by a strong majority as long different people liked and disliked different aspects of it. If the balance was right, people would live with the elements they were not happy with in order to see the overall product succeed.

Our list of elements to be balanced was a substantial one, which I think conveys a sense of the complexity of the task. Over time we crafted a document that strived to

- present recommendations that were politically feasible yet also consistent with the overarching vision for transformational change;
- articulate recommendations that were at a high enough level to be applicable in a wide variety of circumstances, yet specific enough to provide guidance for actual policy change;
- advocate for significant change ("transformation" in the words of *Toward Recovery and Well-Being*) without casting aspersions on the day-to-day work of the many thousands of dedicated practitioners who do their best working inside the "system" in need of "transformation";
- recognize the critical importance of upstream measures to improve population health and well-being while adequately addressing the many urgent issues relating to the day-to-day provision of supports and services;
- create a framework that embraces "lived experience" while also valuing the importance of professional expertise;
- move beyond a narrow focus on the healthcare system in order to address all the social determinants of health without moving outside the scope of a mental health report or pretending that such a report could, on its own, solve the complex problems of inequality and discrimination that continue to bedevil Canadian society;
- acknowledge the intensity of need of the approximately 3% of the population who live with "serious and persistent" mental health problems while simultaneously addressing the "mild to moderate" conditions experienced by 17–20% of Canadians;
- uphold the idea that the underlying principles of a recovery orientation are applicable across the entire mental health system while recognizing the need to adapt the way they are applied, most notably with respect to addressing mental health needs across the lifespan;

9 Policy work of this kind is necessarily the product of teamwork and the Strategy would not have been completed without the hard work and dedication of those who worked on it, and their determination to surmount the numerous challenges we confronted along the way.

- defend the right of people living with mental health problems and illnesses to direct their own journey of recovery while also encouraging the greatest possible involvement of family;
- confront the particularly acute needs of rural and remote regions of the country without losing sight of the fact that there are serious issues of access to supports and services everywhere;
- recognize the specificity of needs and the particular forms of exclusion that arise from the many dimensions of diversity in our country while also anchoring our work in the understanding that all voices of lived experienced had to be heeded and the reality that the entire mental health sector has suffered from years of neglect;
- respect jurisdictional boundaries and the constitutional division of powers while providing a blueprint for change that would be relevant everywhere;
- address the trans-generational legacy of colonialism and attempts at assimilation on First Nations, Inuit, and Métis while also paying careful attention to the needs arising from all the different dimensions of diversity in our country;
- acknowledge the value of knowledge derived from culture and tradition in sustaining mental health and well-being while advocating for the importance of expanding and applying a scientific understanding of mental health and mental illness;
- call for a paradigm shift without alienating those who support approaches (such as the "medical" model) that have long dominated the field; and
- foster respect for the many different ways in which people understand their own mental health and well-being while still challenging all forms of behaviour that can be detrimental to well-being.

Overall, I would argue that we succeeded in producing a balanced and comprehensive strategy that managed to walk the many fine lines required to navigate this somewhat daunting list. Reaction to the Strategy was positive across the mental health community and its release garnered considerable (if fleeting) media coverage. Producing a "balanced" report did not mean that we abandoned foundational principles in the name of "consensus" or that the report renounced its commitment to "transformational" change. Rather, I think that the balance we achieved successfully applied the core values and principles of a recovery orientation to the reality of the Canadian mental health system, and the resulting recommendations chart a way forward for the process of transformation.

**Roads Not Taken**

However, this necessary focus on balance came at a cost. It meant that the Commission could not impose an explicit hierarchy amongst the Strategy's recommendations. There were 109 recommendations in the Strategy and the de facto approach to implementation left it up to stakeholders—governmental, professional, and grassroots—to establish their own priorities.

The Commission did consider whether it would be advisable to establish some initial priorities that would provide guidance on how to implement the Strategy step by step. This idea was rejected, however, because narrowing the focus meant that the Commission would be breaching its commitment not to tell

individual governments what to do. The Commission could present a menu of choices in the Strategy but it could not specify which of these should be the priority for any specific government.

But this left a problem. To be a champion for the Strategy without a focus on a small number of recommendations meant it would be necessary to advocate for all 109 recommendations simultaneously, something which is clearly not really possible. In this sense, one cannot advocate for the Strategy simply as a "document," either with government or with the public at large. But, it then becomes difficult to see how, concretely, the Commission could have acted as overall champion for the Strategy.

The approach that seemed to me to be most promising, but which was never embraced, was for the Commission to take a lead role in a broad public campaign around a concrete issue such as a national campaign on depression and suicide. While this was not itself a recommendation in the Strategy, such a campaign might have been able to focus attention on the relevance of key recommendations from the Strategy and mobilize a substantial proportion of the mental health community (in keeping with the Commission's earlier vocation to help "build a movement"). Leading a public campaign could have been a way to champion the Strategy without simply touting it as a "document."

In addition to this "public campaigning" role, it is also worth thinking about a second road that was not taken—the one that could have enabled the ACs to continue to contribute to the Commission's work. Whatever the reason for having abolished the ACs in the fall of 2012,[10] the consequence was to constrict the ways in which the Commission could interact with the mental health community. The eight advisory committees had provided a bridge to the real world of mental health activity and their work had contributed to the sense that a "movement" might be developing around mental health.

They might have been able to play that role even more actively in encouraging the implementation of the Strategy, but by getting rid of the ACs the Commission pushed away a powerful body of advocates, many of whom had started to see themselves as part of the "Commission's family." The ACs had significantly contributed to the development of the first national mental health strategy but the Commission chose not to mobilize them to explore avenues for realizing the Strategy's recommendations, or to expand the already substantial body of policy thinking that they had begun to create on their own.

Moreover, it might also have been possible for the ACs to become the core around which the "social movement" Kirby sought to bring into being could have been built. Over the course of the Commission's first five years a nascent national network of mental health advocates began to radiate from the ACs. The members of the ACs had demonstrated their commitment to working with the Commission and with their respective constituencies. But none of the strategies to build a grassroots movement ever seem to have considered using the ACs as a key pillar of support.

**Funding Issues and What Needs to be Done Today**

The Strategy concluded with a call for greater government investment in mental health. There were a number of challenges here. We had not costed the recommendations we were proposing, either in whole or

10 I remember one conversation in which one of the reasons adduced for the abolition of the ACs was that it would be impossible to defend the cost of supporting them to government.

in part. To have done so would have required us to translate the high-level recommendations into specific programs and develop a much deeper understanding of exactly how mental health dollars were already being spent in every corner of the country. I suspect that even under the best of circumstances this would not be possible, but we had neither the time nor the resources to even try.

As well, the more specific that a recommendation becomes—for example by calling for a particular program to be implemented everywhere—the more prescriptive it is. And it was simply not possible for us to dictate particular programs that had to be applied in every part of the country, which is what the costing process would have demanded.

However, early on in the drafting of the Strategy we had commissioned a study from the Institute of Health Economics at the University of Alberta on mental health spending in the country. It provided us with a calculation of the percentage of public health care dollars that was being spent by all levels of government on mental health. It came in at around 7%—that is, on average, 7 cents of every publicly funded healthcare dollar was going to mental health. While there are no universally accepted benchmarks for what is the right percentage for mental health spending, this was definitely low, whether in comparison to similar countries or in relation to the total burden of disease represented by mental health problems and illnesses.

The question was how best to frame a recommendation around this number. We decided to call on governments to increase the percentage that was being spent on mental health by two percentage points (that is, from 7% to 9% of publicly funded healthcare dollars). Such an investment—roughly $3 billion per year—would make a real dent in the spending gap, but at the same time did not seem likely to cause sticker shock and be ruled out of hand by cost-conscious governments.

We were not able to specify exactly who should contribute how much, or where the money should come from. The number we had was a national average and the Commission was prohibited from creating "league tables" that compared jurisdictional performances. So while we could not break down spending by jurisdiction, the call was implicitly for the increase to be shared so that each jurisdiction increased its spending on mental health by two percentage points.[11] In retrospect, it might have been possible to go a bit further and resuscitate the call from *Out of the Shadows* for the federal government to create a targeted mental health transfer fund to cover a good part of the needed increase in mental health spending. At the same time, I am not at all sure that this would have made any difference since, given the Harper government's hands off attitude to health transfers to the P/Ts, such a recommendation would have had little hope at that time to be implemented.

At the time of writing, the Liberal government has negotiated targeted funding for mental health initiatives as part of the Health Accord with the P/Ts. By the time this article appears we may know more about how this money will be spent. In my view, targeted federal funding is by far the most promising option for beginning to redress the historical neglect of the mental health sector. In fact, it is hard to argue with the proposition that the single most important way for governments to enhance mental health services and supports would be to boost investment.

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11 In recognition of the fact that there is much mental health spending that occurs outside the health system, we also recommended a parallel two percentage point increase in "social" spending on mental health, without, however, being able to provide an estimate of how much this represented.

It is, of course, not only about pumping in more resources—how they are to be used is of critical importance. But even an expansion of services that operate mainly as they currently do would increase the opportunity for many people to get access to the support and care they need. And if the conditions for accessing additional federal funds were somehow tied to acting in accordance with the Strategy's recommendations then we could also hope to see an improvement in the quality, range, and nature of supports and services that become available.

I also believe that the impact of improving mental health and well-being in line with the Strategy's approach could also help to set an example for the entire healthcare system. The vision for change developed in the Strategy, and widely embraced by stakeholders, is also relevant for building a healthcare system that is centred on the "patient," treats people as whole human beings rather than as manifestations of illness, and takes into account all the circumstances of their lives. If I am right about this, it is an indication that having to confront the challenges of figuring out how to improve mental health and well-being for everyone living in Canada provides us with insights on how to make our country a better place to live for all of us.

Still, at the close of the MHCC's ten-year mandate, the Strategy remains a reference point for mental health policy rather than a true guide to government action. If Kirby was right that little would happen without grassroots pressure, this is unlikely to change soon. At the same time, mental health is much more visible on both the public and the policy agendas. It remains my hope that the path forward outlined in the Mental Health Strategy for Canada can help to guide decision makers and the rest of us towards a future of improved mental health and well-being.