Mental Health Institute Design

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Mental Health Institute
One-Page Executive Summary

In consideration of: the bio-psycho-social nature of most mental health concerns; the resulting opportunities for building transformative research; the high burden of morbidity and mortality caused by mental health related problems; their associated social and economic costs; the need for national research priorities to coordinate and target funds to the most important public health challenges; the importance of developing a foundation of health system evidence to guide mental health reforms; the need to build both research capacity and uptake of research findings by decision-makers and consumers; and the need to incorporate a broad range of consumers and stakeholders in the mental health research process, we strongly recommend that a Mental Health Research Institute be created under the auspices of the Canadian Institutes of Health Research.

Further we propose that the Mental Health Research Institute: (a) operate in a broker capacity between the Canadian Institutes of Health Research Governing Council and central administration, funders, researchers, decision-makers, consumers, and other stakeholder groups to promote integrative and transformative research, (b) participate in centralized peer review processes and undertake and Institute-based merit review of all mental health related research, (c) directly fund capacity-building initiatives in the form of workshops, networks, and consortia, (d) take a leadership role in the development and funding of a national mental health research agenda, and (3) advocate for mental health concerns by developing innovative programs that could be funded under the aegis of the Canadian Institutes of Health Research.
Mental Health Institute
Three-Page Executive Summary

Research into mental illness and mental health has lagged behind its burden of disease in the population, and mental health research has been under-represented in national funding competitions. For example, while mental health related conditions constitute the second leading category of direct health care costs (11.4% of total direct costs and 14% of hospital costs), they command only 4% of research funding. Factors contributing to this have been a shortage of trained mental health researchers and the difficulty for mental health research issues, which are based on a bio-psycho-social model, to fit neatly into traditional discipline-specific funding structures. The integrative nature of the new Canadian Institutes of Health Research should foster the bio-psycho-social approaches that are necessary to further knowledge in this field. A Mental Health Institute devoted to capacity building, particularly with respect to cross-cutting research, could: promote stronger inter-disciplinary collaboration around common and important population health issues; provide opportunities for mentoring for young researchers; create a network of mental health researchers that is multi-site, and multi-disciplinary; improve the uptake of research knowledge in health services and policy spheres; and take a leadership role in developing structures and processes designed to obtain broad stakeholder involvement in the setting of national priorities for the field. Perhaps most importantly, a Mental Health Institute could reduce the stigma of mental illness by providing a visible rallying point for research into an important but often marginalized and underfunded population health problem.

The burden of mental health related problems in the population has been seriously underestimated. Not only are they linked to certain physical illnesses and increased mortality from suicide, they also bear a complex and poorly understood relationship to many of the most toxic public health problems of our day, such as interpersonal violence, criminality, addictions, homelessness, and poverty. They are
associated with significant emotional suffering and disability, and have important, but largely unrecognized human and economic costs. The disability caused by mental health problems is comparable to that caused by major physical diseases such as cancer or cardiovascular disease. Indeed, psychiatric illnesses rank among the top five leading causes of disability, and are second only to heart disease as a cause of general hospital utilization. By the year 2020, five of the top fifteen leading causes of disability world-wide will be neuro-psychiatric conditions. Depression is expected to rise to the second leading cause of disability world-wide and the first leading cause in developed countries.

The burden of disease and disability associated with mental health conditions is immense. One in five Canadians will suffer a mental illness each year and one in ten will think about committing suicide at some point in their lives. Four percent will make a suicide attempt. People with a psychiatric disorder are six times more likely than those without to experience suicidal ideation, and eight times more likely to make a suicide attempt. Moreover, the risk of suicide seems to be increasing with each successive birth cohort. The broad social costs of mental illness and mental health problems are only now becoming known. For example, workers with a mental health or emotional problem lose an average of 7.6 days of productivity each month; about four times that of workers suffering physical conditions. Mental health related social problems are also becoming more visible in the wake of workplace violence and mass shootings in Canada and elsewhere. Spousal abuse occurs three times as often, and child abuse twice as often among those with a history of psychiatric illness. Alternatively, physical abuse has been the single most important context yet defined for female alcoholism and psychiatric problems. In some surveys, up to half of all female psychiatric patients have been physically or sexually abused. In Ontario, 31% of males and 21% of females report a history of physical abuse, and 4% of males and 13% of females report a history of sexual abuse, raising the issue of interpersonal violence to the level of a major public health problem. At the level of mental health reform, there is a need to bring research to bear on key policy decisions. Well-intentioned but poorly researched social and mental health policies in the past may have contributed to some of the major system and delivery challenges of our day. For example, up to half of homeless populations are
suffering from a mental disorder, with a third or more having concurrent substance abuse problems. Two-thirds of newly remanded inmates meet the criteria for a mental illness or substance abuse problem. Often they are arrested on minor charges as a means of obtaining institutionally-based supports and as a back-door to obtaining psychiatric treatment.

In light of the pervasiveness of mental health problems, and in recognition of the enormous burden of disease, disability, and ill-health posed by mental conditions, there is need to establish research priorities so that resources may be coordinated to target the most relevant of these concerns. Further, in consideration of: the bio-psycho-social nature of mental health problems; the resulting opportunities for building transformative research; the importance of developing a foundation of health system evidence to guide mental health reforms; the need to build both research capacity and uptake of research findings by decision-makers and consumers; and the need to incorporate a broad range of stakeholders in the mental health research process, we **strongly recommend that a Mental Health Research Institute be created under the auspices of the Canadian Institutes of Health Research.**

We propose that the Mental Health Research Institute: (a) operate in a broker capacity between the Canadian Institutes of Health Research Governing Council and central administration, funders, researchers, decision-makers, consumers, and other stakeholder groups to promote integrative and transformative research, (b) participate in centralized peer review processes and undertake an Institute-based merit review of all mental health related research, (c) directly fund capacity-building initiatives in the form of workshops, networks, and consortia, (d) take a leadership role in the development and funding of a national mental health research agenda, and (3) advocate for mental health concerns by developing innovative programs that could be funded under the aegis of the Canadian Institutes of Health Research.
Introduction and Background:

The development of this concept paper was one of twenty that were jointly funded by the Social Sciences and Humanities Research Council and the Canadian Health Services Research Foundation as part of a Health Institute Design Grants Initiative. This initiative was intended to assist in the development of the Canadian Institutes of Health Research by soliciting ideas on how the social sciences, humanities, health services, or nursing research should be integrated into the new funding structure. Toward this end, this paper:

- provides a rationale for developing a Mental Health Research Institute,
- proposes a design for the Mental Health Research Institute, and
- identifies important stakeholders in the field who would either have the potential to compete for national funding under the aegis of the proposed Mental Health Institute, or would be involved in the development and execution of funded projects through partnership arrangements (these are identified in Appendix A).

Process to Obtain Ideas and Input:

Input for this paper was obtained during a National Consultation Workshop held on September 10-11, 1999, at the Douglas Hospital in Montreal—a World Health Organization Collaborating Centre for Research and Training in Mental Health since 1982. Despite the relatively short lead time for organization (a function of the grant deadlines), this workshop was attended by some 70 individuals who represented the main constituencies in mental health: consumers, volunteer organizations, policy-makers, service providers, researchers, and four national professional organizations representing psychiatrists, psychologists, social workers, and nurses. Consumer interests were represented by five members of the National Alliance for Mental Illness and Mental Health. The National Alliance is composed of five organizations: The Mood Disorders Association of Canada, the National Network on Mental Health, the
Schizophrenia Society of Canada, the Canadian Psychiatric Association (representing 3,000 members), and the Canadian Mental Health Association (one of the oldest voluntary organizations in Canada, founded in 1918). For the past year, these partners have been involved in a consensus-building process—one goal of which has been to develop a proposal for an “Institute of Mental Illness and Mental Health” to function under the Canadian Institutes of Health Research. Academic centres were represented by six Chairs of Psychiatry, two immediate Past Chairs of Psychiatry, and one Endowed Chair of Psychiatry, Law, and Ethics. The current Association of Chairs of Psychiatry in Canada (representing sixteen academic departments) has also been involved in a consensus process and has proposed an Institute of Mental Illness and Mental Health to the Interim Governing Council. A copy of their report was obtained for background information.

The views of policy-makers were represented by a number of government-based representatives who have been active in mental health initiatives at both the provincial and federal levels. There were also representatives from the legal community (The Ontario Review Board and Corrections Canada), psychiatric hospitals in various parts of the country, psychiatric research institutes, and specialized research centres. A broad spectrum of basic and applied clinical research disciplines were also represented including: nurses, social workers, psychologists, psychiatrists, sociologists, psychiatric rehabilitation specialists, anthropologists, ethicists, criminologists, lawyers, biomedical scientists, mental health services researchers, and epidemiologists. Principal Investigators from two other Design Grants (Addictions and Human Consciousness) were also in attendance. Preparatory to the workshop there were telephone conversations, teleconferences, and email correspondences with various stakeholders, some of whom were unable to attend.

**Options Considered:**

Workshop participants were instructed in the broad mandate and goals of the Canadian Institutes of Health Research, the four cross-cutting research sectors, epidemiologic data outlining the burden of mental disorders in the population, and
examples of three different models for integrative research in mental health currently underway or under development in Canada. Two of the models, in Quebec and Ontario respectively, currently receive provincial funding and are fully operational. The “Quebec” Mental Health Research Network model has been in place for approximately five years and has integrated provincial researchers from biomedical, applied clinical, health research, and population health to address important problems such as suicide. The “Ontario” model integrates multiple community-based mental health centres around a coordinating research centre to build capacity for mental health services research and evaluation. Thirdly, the Canadian Alliance for Mental Illness and Mental Health presented the model that is emerging from their consensus process. While not currently in operation, this model is being specifically designed with the mandate of the Canadian Institutes of Health Research in mind.

Workshop participants were divided into four groups for brainstorming. They were asked to ratify the need for a Mental Health Research Institute and suggest possible working models. There were no restrictions on the brainstorming exercise. Groups discussed all types of models; those currently in existence, as well as novel ones that came out of the group discussions. These ranged from bricks-and-mortar institutes (such as the National Institute for Mental Health in the United States), to human consciousness and mental health as cross-cutting themes. While groups worked independently from each other, a strong consensus emerged regarding the need for a separate and visible rallying point for mental health research through an Institute, as well as its key functions. We have used this information to form the basis of our own conceptualization of the roles, functions, and working model for an Institute of Mental Health Research.

≈ Rationale for a Mental Health Research Institute:

Throughout this document, mental illness related issues are considered to encompass a wide range of emotional, behavioural, and psychiatric problems associated with dysfunction and impairment, as well as lower-intensity problems and mental health
concerns that may reflect early stages of disorder, reactions to violence, or problems in family functioning. In addition, and equally relevant, are issues related to the development of mental health, such as factors influencing healthy mental functioning, good self-esteem, pro-social behaviour, and positive social environments. In the Institute title we use the term “mental health” to encompass this full range of mental illness and mental health related issues, partly out of expediency, and partly in an attempt to de-stigmatize the study of mental illnesses.

A separate Institute devoted to research on mental illness and mental health can be justified from a number of perspectives.

There is Need for a Mental Health Research Institute to Foster the Development of Basic and Applied Knowledge that Can Be Used to Improve Population Health and Reduce the Burden of Mental Illness and Disability in the Population.

The burden of mental health related problems in the population has been underestimated. Not only are they linked to certain physical illnesses and increased mortality from suicide, they also bear a complex and poorly understood relationship to many of the most toxic public health problems of our day, such as interpersonal violence, criminality, addictions, homelessness, and poverty (Thompson & Bland, 1995). They are associated with significant emotional suffering and disability, and have important but largely unrecognized human and economic costs (Neugebauer, 1999).

Regarding the burden of illness on the population, one in every five adult Canadians will suffer a mental disorder this year. As well as having a poorer quality of life, one in five of these individuals will experience significant dysfunction in daily activities, and one in five will lose productivity in the workplace. In addition, one in four will experience troubled marital relationships, and one in seven will have a troubled relationship with their children (Bland, Newman, & Orn, 1988; Goering, Lin, Campbell, Boyle, Offord, 1996; Offord Boyle, Campbell, Goering, Lin, Wong, & Racine, 1996).
Children’s mental health problems include syndromes that meet psychiatric diagnostic criteria as well as those involving developmental delays, serious family disturbances, and other psychosocial problems. Surveys show that as many as one in five youth may have a mental disorder. Up to half of these (some 11% of the youth population) will have sufficient impairment to warrant treatment (Riley and Wissow, 1994).

The disability associated with mental health problems is comparable to that caused by major physical illnesses such as cancer or cardiovascular disease (Barchas, Elliott, Berger, Barchas, & Solomon, 1985). Indeed, psychiatric illnesses rank among the top five leading causes of disability (along with heart disease, cancer, respiratory disease, and stroke), and rank second only to heart disease as a cause of general hospital utilization (Riley & Richman, 1991). By the year 2020, five of the top fifteen causes of disability world-wide will be neuro-psychiatric conditions. Depression is expected to rise to the second leading cause of disability worldwide and first leading cause in developed countries (Desjarlais, Eisenberg, Good, & Kleinman, 1995).

Suicide mortality associated with psychiatric disorders is also high. Suicide ranks in the top five causes of potential years of life lost for Canadian men and women (Wilkins & Mark, 1992). It is the second leading cause of death (after accidents) among youth aged 15-24 years (Sigurdson, Staley, Matas, Hildahl, & Squair, 1994). Approximately one in ten Canadians will think about committing suicide at sometime in their lives, and four percent will make a suicide attempt—83% of those with a mental disorder (Dyck, Bland, Newman, & Orn, 1988; Bland, Newman, Dyck, 1994). Those with a psychiatric disorder are six times more likely than those without to report suicidal ideation, and eight times more likely to make an attempt (Moscicki, O’Carroll, Rae, Roy, Locke, & Regier, 1989). There is also considerable evidence to indicate that the risk of suicide has been increasing with each successive birth cohort this century, although the various age, period, and cohort effects over time has been difficult to tease out (Solomon & Hellon, 1980; Reed, Camus & Last, 1985; Barnes, Ennis & Schober, 1986; Trovato, 1988; Wasserman, 1989). No consensus has yet been reached on the relationship between the availability of lethal methods and suicide rates, however, many believe that
stricter control of lethal substances (such as domestic gas, car exhaust emissions, or psychotropic medications), as well as gun control laws can be important deterrents (Holley, 1993).

In the health care system, mental illnesses can be treated in a variety of inpatient and outpatient locations, in specialty and primary care settings, hospitals, nursing homes, and in long term care. This makes the total costs to the health care system difficult to quantify. Health Canada (1997) estimates that some 8% of physician care expenditures, 8% of drug costs, 14% of hospital care, and 3% of research costs are associated with mental disorders. Eleven percent of the total direct costs of health care was attributed to mental illness, making them the second most costly disease category (following cardiovascular disorders which account for 16.7% of direct costs).

Mental health problems place a high burden on outpatient and primary care. For example, eight percent of Ontario residents seek treatment for a mental health reason each year. Most of these (94%) seek outpatient care, and half are treated in the primary care sector (Lin, Goering, Offord, Campbell, & Boyle, 1996). Up to half of patients with psychiatric disorders also have accompanying medical disorders (Kinmonth & Thompson, 1997). However, only about half of those presenting to primary care physicians will be correctly identified as suffering from a psychiatric or emotional problem (Goldberg, 1995). Of those recognized, only a small proportion will be referred to the specialty mental health sector—often those with serious and persistent mental illnesses who fail to respond to primary care treatments (King 1998). On the other hand, a small group of severely and persistently mentally ill (some 7%), account for half of all physician visits (Mustard, Derksen, & Tataryn, 1996).

The establishment of new psycho-pharmacologic treatments for mental illnesses, the reduction in hospital beds, and the emergence of a community-based treatment philosophy have meant that only very seriously or acutely ill patients are hospitalized. Nevertheless, mental disorders remain the second leading cause of hospital days in
Canada, following heart disease (Riley and Richman, 1991). In 1993/94 over fifteen million hospital days were provided to Canadians with psychiatric disorders, representing a huge financial investment for the health care system. Approximately one third of these were provided in general hospital psychiatric units (where the stays tend to be shorter) and two-thirds were provided in specialized psychiatric hospitals (where the stays tend to be longer) (Randhawa & Riley, 1996).

A number of broader social costs are also associated with mental health related problems.

- The effects of mental health and illness on workplace productivity, and therefore the economy, is only now becoming recognized. It has been estimated that 7% of Canadian workers report absentee days attributable to mental and emotional problems (Perez and Wilkerson, 1998). Mental and emotional problems place a greater burden on workplace productivity than do physical problems. In Ontario, for example, workers with a mental condition average 7.6 days of diminished or lost productivity per month; about four times that of workers with physical conditions. According to the World Health Organization, emotional and mental conditions are one of the fastest rising reasons why workers take long-term disability, indicating that these conditions are both costly and have a long term impact (Dewa and Lin, 1999). In Canada, lost productivity due to long term mental disabilities costs $1.6 billion annually, and lost productivity due to short term disabilities costs over $800 million annually, making mental disorders sixth and seventh most costly causes of worker disability respectively (Health Canada, 1997).

- Concerning social and interpersonal violence, mental health related problems are becoming more visible in the wake of workplace violence and mass shootings. In the United States, where the bulk of these incidents have occurred, workplace assaults and violent acts cause 20% of occupational deaths, second only to transportation deaths (Peek-Asa & Howard, 1999). While the level of social violence in Canada is much lower, incidents such as
the Taber school shooting in Alberta remind us that Canadians are not immune to such problems.

- **Domestic violence** is often linked with mental and emotional problems, both as a cause and as a consequence. For example, spousal abuse occurs three times more often, and child abuse twice as often among those with a history of psychiatric illness (Bland 1988). The New York State National Women's Abuse Prevention Program estimates that: 95% of the victims of domestic violence are women; wife-beating results in more injuries that require medical treatment than sexual assaults, automobile accidents, and robbery; 30% of female victims of homicide are killed by their partner; abused women constitute 20% of the women with injuries in hospital emergency rooms; and 21% of pregnant women are abused and these women have twice the number of miscarriages as women not subjected to abuse (Vazquez, 1996). Indeed, physical abuse is the single most important context yet defined for female alcoholism and psychiatric problems. In some surveys, up to half of all female psychiatric patients have been physically or sexually abused. More than one third of these experience depression or another situational disorder, and one in ten suffer a psychotic break (Stark & Flitcraft, 1988). In Ontario, 31% of males and 21% of females report a history of childhood physical abuse, and 4% of males and 13% of females report a history of childhood sexual abuse (MacMillan, Fleming, Trocme, Boyle, Wong, Racine, Beardslee, Offord, 1997). Canadian National Population Health Survey data shows that for both genders, the presence of childhood victimization increases the likelihood of a major depressive disorder as an adult. Indeed, cumulative victimization increases the odds of depression by two times (for one event), four times (for two events), and five times (for more than two events). Among women, those experiencing any victimization as an adult are 3.5 times more likely to have a major depressive episode. These findings indicate that victimization during childhood or adulthood are significant risk factors for depression (Arboleda-Flórez & Wade, in press).
There is Need for a Mental Health Research Institute To Set National Priorities For Mental Illness and Mental Health Research.

In light of the pervasiveness of mental health and related problems, and in recognition of the enormous burden of disease, disability, and ill health posed by mental conditions, there is a clear need to establish research priorities and to coordinate resources to target the most pressing population mental health problems. Toward this end, mental health research should be “mainstreamed” into an Institute and linked with other scientific activities aimed at improving population health (Üstün, 1999). For Kinmonth and Thompson, “mainstreaming” of mental health research means building a cadre of researchers that are capable of articulating clear, soluble, and relevant research questions then collaborating with the various research disciplines necessary to solve them; developing the research infrastructure necessary to conduct robust and pragmatic studies; and linking findings with teaching so that effective dissemination of good practice occurs.

While we have become accustomed to reading about national strategies to address economic, political, or general health issues, national strategies for mental health research are virtually unprecedented in Canada. One exception is The National Strategy for Research on Schizophrenia. Although initially spearheaded by The Schizophrenia Society of Canada, a consumer advocacy group, this strategy ultimately involved the full spectrum of research stakeholders. Moreover, it resulted in the development of a research structure—The Canadian Alliance for Research on Schizophrenia, which was not too unlike a virtual Institute in the present understanding of the term. The research strategy produced was published in a full volume of the Journal of Psychiatry and Neurosciences (Volume 19, 1994). It addressed the state of knowledge and made recommendations for research priorities in six areas: methodology and instrumentation; psychosocial research; service delivery; psychopharmacology; genetics; and neurobiology and imaging. Despite the ground breaking work of the Canadian Alliance for Research on Schizophrenia, their research strategy was never incorporated into national funding priorities, nor supported in any
visible way by funding bodies. A Mental Health Research Institute would have been a natural incubator for such an initiative, helping to build research capacity and research opportunities in the priority areas identified. In the future, a Mental Health Research Institute would take a leadership role in similar planning initiatives and work with advocacy groups, such as the Canadian Alliance for Mental Illness and Mental Health, to develop national research priorities and funding opportunities.

**A Mental Health Research Institute is Needed to Foster Health Systems Research Aimed at Guiding Mental Health Reform…..**

“There is a chance, but no guarantee, that scientific understanding of human behaviour would open pathways into patterns of living that would save us from wasting and destruction. So far in the history of the world, neither religion nor secular philosophy has been able to divert mankind from massive destruction and monstrous cruelties. Applying science to man’s behaviour is the one thing that has not so far been seriously tried” (Leighton, 1993, p. 456).

Many major shifts in psychiatric treatment, and most of the influential ideas in mental health, have been based on small and opportunistic samples, or no sample at all (Leighton, 1990). Important treatment and funding decisions have often been made without knowledge of their impact on treatment access for the mentally ill. For example, built on the belief that mental hospitalization created unhealthy dependencies and fractured family ties, a community mental health treatment philosophy developed. Almost overnight psychiatric hospitals were downsized and chronic mental patients were transferred from hospitals to community-based living arrangements. In locales having proper funding and aftercare, long-stay inpatients fared well in residential settings (Dayson, 1993; Lesage, Contandriopoulos, Reinharz, 1999; Rothbard, Kuno, Schinnar, Hadley, Turk, 1999). However, in many areas, the full range of community-based services were never sufficiently funded nor coordinated to provide the social safety net required by these chronically disabled individuals to maintain a healthy community existence (Rochefort, 1993). In these areas the community mental health treatment philosophy never realized its full potential.
One consequence of the lack of a coordinated network of community based mental health and social programs has been that our jails now routinely house more psychiatric patients than our psychiatric hospitals (English, 1993). These individuals are typically arrested for minor charges relating to public displays of disordered or fear-inducing behaviours. Once in jail, they may be referred for forensic psychiatric assessment and/or treatment. In Alberta, approximately one of every three newly remanded inmates suffers from a serious and treatable mental disorder. Another third have a substance abuse problem (Bland, Newman, Dyck, & Orn, 1990; Arboleda-Flórez, Love, Fick, O’Brien, Hashman, & Aderibigbe, 1995). The gradual shifting of responsibility for care and custody of the seriously mentally ill from mental health to criminal justice systems is known as “the criminalization of the mentally ill” and it illustrates the importance of evaluating policy impacts across several systems and sectors.

Mentally ill are also over-represented in homeless populations. In a sample reflecting the population of shelter users in Toronto, half were suffering from a mental disorder and 38% also had a concurrent substance use disorder (Tolomiczenko & Goering, 1998). In another Canadian study conducted in Calgary, three quarters of homeless shelter-users reported some psychiatric symptomatology, and one third reported a significant mental health problem. Those with psychiatric problems experienced more hardships while on the streets, took greater public health risks, more often abused substances, were more often victimized, suffered greater economic and inter-personal life events, experienced greater dissatisfaction, and suffered more stress. While they frequently needed and wanted mental health services, they often did not know where to access them (Stuart & Arboleda-Flórez, in press).

Complex legal and legislative issues also surround the care and treatment of the mentally ill. In every province, mental health legislation permits the civil commitment (i.e. involuntary hospitalization) of individuals who are suffering from a mental disorder and in danger of hurting themselves or others (Arboleda-Flórez & Copithorne, 1994; Crisanti,
1998). Outside of mental health legislation, only judges have the right to remove an individual’s liberty. In most provinces, civil commitment legislation is restricted to inpatient hospitalization, but there is growing interest in applying the principles of commitment to outpatient care in order to mandate community treatment for certain chronically ill individuals under specified circumstances—still a matter for considerable debate. As provincial governments struggle with health care cuts; as they look for ways to further reduce psychiatric hospital beds; and as they develop more effective and assertive community based care options, there is a need (indeed some urgency) to foster evidence-based policy, practice, and accountability through health systems research conducted at the legislative, policy, and service levels. Only in this way will it be possible to redress the mistakes made in the past.

**A Mental Health Research Institute is Needed to Build Research and Uptake Capacity in the Mental Health Field:**

A research funding snapshot for mental health was prepared in 1990/91 from peer-reviewed research grants disbursed by 48 of the major Canadian funding agencies (Lam and el-Guebaly, 1994). It covered national, provincial, and most of the private non-profit agencies devoting funds to research in mental health. Although likely an underestimate, it remains our best reflection of the national state of peer-reviewed funding for mental health research. (Neuroscience grants were included if they related to a specific psychiatric condition.) Total research funding for psychiatric disorders ($16,406,300 during that fiscal year) represented 3.7% of the total biomedical research funds disbursed. During that same year, the total direct costs of providing mental health care were estimated to be 11% (and 14% of hospital costs) (Health Canada, 1997). The largest research disbursements (54% or $8,791,870) were from the two federal sources—The Medical Research Council and Health and Welfare Canada—representing 3.3% of all federal research funds. Provincial sources amounted to 39% of total mental health funding ($6,362,000), representing 8.7% of all provincial research funding. Private and non-profit agencies and foundations, such as the Alzheimer’s Society of Canada (which disbursed $500,000) and the Canadian Psychiatric Research Foundation (which disbursed $341,000) accounted for the remaining 7.6% of psychiatric research funding. The $16.4 million disbursed in peer-reviewed research during the 1990/91
fiscal year totaled the amount of a single day of psychiatric treatment in Canada—about $3.90 per patient. The largest proportion of funds were devoted to dementia research (19%). The rank ordering of the remaining four leading categories approximated the rank ordering of the leading causes of psychiatric hospitalization: mood disorders (17%), schizophrenic psychoses (10%), alcohol/drug dependence (7%), and anxiety disorders (5%).

Considering that psychiatric disorders consume some 11% of direct health care costs in Canada and 14% of hospital costs, but account for less than 4% of peer-reviewed research funding, an important challenge will be to raise the proportion of mental health research funding to be more commensurate with the burden of illness and social costs of mental health problems. A main reason for the under-representation of mental health research in national funding competitions has been the lack of trained mental health researchers (Lam & el-Guebaly, 1994; Pincus, Dial, & Haviland, 1993). Thus, a second challenge will be to increase the number of peer reviewed mental health related grants. This can be accomplished by building capacity for research; by fostering the development of mental health researchers; and by increasing the opportunities for competitive, interdisciplinary research funding in mental health.

**A Mental Health Research Institute is Needed to Foster Consumer Advocacy and Consumer Involvement in Mental Health Research:**

Consumer advocacy groups view the inequities in research funding for mental illness, and the historically low priority of mental health concerns, as clear reflections of social stigma and discrimination. All over the world such groups are forming strong alliances to fight such stigma and discrimination. They are beginning to lobby governments to increase the relevance of mental health and illness related issues in national research and health care agendas. International programs, such as the World Psychiatric Association’s Global Program to fight stigma and discrimination because of schizophrenia are now underway and accumulating significant momentum in this respect (Dubey, 1999). In the United States, consumer groups such as National Alliance for the Mentally Ill, have improved the proportion of research funds allocated to the bio-psycho-
social aspects of mental and behavioural disorders. In Canada, the fledgling National Alliance for Mental Illness and Mental Health is committed to developing a national research agenda. Toward this end, they will lobby the Canadian Institutes for Health Research to develop an Institute of Mental Illness and Mental Health Research. As previously identified, the Alliance is composed of three national consumer-based organizations (the Mood Disorders Association of Canada, the Schizophrenia Association of Canada, and the National Network for Mental Illness), and two professionally-based organizations (The Canadian Psychiatric Association and the Canadian Mental Health Association). While only a year old, it is gaining momentum and is already taking a leadership role by working with Health Canada to develop a population-based mental health surveillance system.

The rise in consumerism and advocacy for mental health will create important challenges for both researchers and funders. Not only will obvious funding inequities be increasingly targeted for redress, it will become necessary to establish mechanisms through which consumer and advocacy organizations can have a role in setting national research priorities and establishing a national research funding agenda.

The Bio-Psycho-Social Nature of Mental Health Related Problems means that a Mental Health Institute Could Take a Leadership Role in Transforming Research in Canada.

The Canadian Institutes of Health Research defines “transformative” research as that which integrates researchers from four distinct scientific communities (bio-medical, applied clinical, health services, and population sciences) to address questions that could, if answered, improve the health of Canadians. The scope of medical research will broaden to give greater recognition to the social and psychological determinants of health and illness. As well, more applied research addressing important health system and policy questions will be fostered. The enduring challenge for the Canadian Institutes of Health Research, and for the Canadian research community, will be to convey the importance of this broadened research paradigm through example. The bio-psycho-social nature of mental health related problems will provide rich opportunities for
scientists from the four research sectors to undertake transformative research of the type envisioned. The previous lack of fit between traditional discipline-specific funding structures and the bio-psycho-social models used to understand mental health problems has been an important deterrent to research funding in this area.

Although difficult to fund through national funding councils, several good examples of transformative research in mental health are already underway in Canada. All are funded through provincial sources. The Suicide Axis in Quebec, for example, brings the full range of research perspectives—from molecules to community—to bear on the issue of suicide to identify better prevention, treatment, and postvention strategies. Because these initiatives take considerable time, they would be ideal candidates for infrastructure support (in the form of funding for network activities, workshops, or other forms of interaction) organized at the level of the Mental Health Research Institute.

Summary:

Research into mental illness and mental health has lagged behind the burden of disease in the population, and mental health research has been under-represented in national funding competitions. Factors contributing to this have been a shortage of trained mental health researchers and the difficulty for mental health research issues based on a bio-psycho-social models, to fit neatly into traditional discipline-specific funding structures. The integrative nature of the new Canadian Institutes of Health Research should foster the bio-psycho-social approaches that are necessary to further knowledge in this field. A Mental Health Institute devoted to capacity building, particularly with respect to cross-cutting research could: promote stronger interdisciplinary collaboration around common and important population health issues; provide mentoring opportunities for young researchers; create a network of mental health researchers that is multi-site and multi-disciplinary; improve the uptake of research knowledge in health services and policy spheres; and take a leadership role in developing structures and processes designed to obtain broad consumer and other stakeholder involvement in setting national research priorities. Perhaps most importantly, a Mental Health Institute could help reduce the stigma of mental illness by
providing a visible rallying point for research into an important but often marginalized and underfunded population health problem.

≈ Mission, Goals and Objectives:

“Mental health represents one of the last frontiers in the improvement of the human condition. ...mental health and health-damaging behaviours exact a tremendous toll in human suffering, evident in the distress and despair of individuals and the anguish of their families, and in the social and economic costs due to lost productivity and increased used of medical and welfare services. The tragedy is even greater because much of it could be avoided were we to commit ourselves to applying what we know and learning what we don’t about prevention and treatment” (Desjarlais, Eisenberg, Good, & Kleinman, 1995; p. viii).

This is a fitting mission for an Institute of Mental Health Research under the auspices of the Canadian Institutes of Health—apply what we know and learn what we don’t about the prevention and treatment of mental illness and mental health damaging behaviours. More specifically, the main goals and objectives of an Institute of Mental Health Research working within the larger Canadian Institutes of Health Research would include:

1. Increasing the number of peer-reviewed projects devoted to integrated (bio-psycho-social) mental health issues by:

   1.1. Increasing the cadre of Canadian researchers capable of successfully competing for national funding by developing early and mid-career training grants;

   1.2. Developing innovative salary-support programs for field-based personnel (such as clinical investigators or government personnel) to undertake or participate in integrated mental health research; and

   1.3. Creating innovative funding opportunities around important mental health problems;
2. Coordinating scarce research resources so that they are used effectively to address nationally relevant mental illness and mental health related problems by:

2.1. Creating and funding mechanisms to set national research priorities and a national research agenda;

2.2. Developing and funding mechanisms to include consumers, voluntary advocacy organizations, policy-makers, and other stakeholder groups in research priority setting; and

2.3. Creating funding partnerships across federal, provincial, and private organizations to jointly address priority mental health-related problems;

3. Strengthening linkages across the four research sectors (biomedical, applied clinical, health services, and population/social sciences) by:

3.1. Creating funding bridges to other Institutes through joint projects designed to investigate mental health and mental illness issues as cross-cutting themes; and

3.2. Fostering multi-disciplinary, multi-sectorial programs of research in the mental health field that address national research priorities;

4. Promoting knowledge transfer and uptake by:

4.1. Funding activities and programs (such as networks, consortia, workshops) that are designed to bring researchers into contact with relevant decision-makers and are explicitly aimed at improving research dissemination and uptake;

4.2. Creating opportunities for partnerships among researchers and mental health policy-makers in support of evidence-based mental health care; and

4.3. Creating opportunities for decision-makers, consumers, and other stakeholder groups to participate in merit panels to review and rank all mental health related projects according to their importance (either theoretical or applied) for current and future research priorities as outlined in the national research strategy;
5. Building competitive research capacity in the mental health field by:

5.1. Organizing and funding appropriate technological and methodological support for research teams having projects that are considered by the Institute-based merit review to be highly relevant, but which fail to pass the centralized peer review process; and

5.2. Funding international expert workshops and visiting scholar/scientist programs designed to improve the knowledge and skills of Canadian mental health researchers.

≈ Institute-as-Broker

The mission and functions of the proposed institute (as outlined in the previous section) support an Institute-as-Broker model. Under this model, the Institute would not manage grants, undertake scientific peer review, or conduct any activities that could be more efficiently undertaken at the central level of the Canadian Institutes of Health Research. Rather, the Institute would function as a broker between the centralized functions of the Canadian Institutes of Health Research and mental health research stakeholder communities (researchers, consumers, decision-makers). Broker activities would centre on creating innovative funding programs and opportunities designed to further the goals of mental health research in Canada. Once created, projects and programs would be managed through a central competitive granting process. Thus, Mental Health Institute staff would broker between:

- consumer, decision-maker, and researcher communities to identify areas for research to improve population mental health,

- consumers, decision-makers, researchers, and the Canadian Institutes of Health Research to develop a national research and funding strategy,

- the various Institutes designated under the Canadian Institutes of Health Research to develop multi-sectorial, integrated research programs that are aimed at the national priority areas;
researchers and end-users of research to foster knowledge transfer and uptake;

researchers to improve research competitiveness for national funding;

researchers and the Canadian Institutes of Health Research centralized peer review process to ensure an appropriate representation of mental health expertise on review committees;

academic institutions and the Canadian Institutes of Health Research funding programs to create research training opportunities for early and mid-career professionals; and

National, provincial, and private funding partners to create joint funding initiatives relating to national mental illness and mental health research priorities.

Following this model, then, the Mental Health Institute would add value to the national competitive funding process by advocating for an appropriate mental health profile in theme-based projects and special initiatives; by capacity-building in the mental health community; and by identifying mental health priorities so that scarce resources could be devoted to problems having the largest population impact.

Because the Mental Health Institute would function as an intermediary between various mental health stakeholder communities and the centralized planning and granting functions of the Canadian Institutes of Health Research, researchers would not be members of the Institute per se. Rather, they would be funded through the Canadian Institutes of Health Research and be active participants in specific Institute-driven projects. Such a structure would allow for flexible and fluid participation in mental health initiatives, encourage cross-cutting participation, prevent the development of Institute-based stove pipes, and avoid the stigma and ‘ghettoization’ that is often the result of segregating mental health concerns from mainstream activities. It may be appropriate for certain training and career awards to be specifically associated with the Institute in name, but these would be funded through the centralized peer review process and
accountable at the centralized level. Similarly, it may be appropriate for certain special projects to be associated with the Institute as Institute-generated initiatives, however these would have to be argued on merit to the central planning framework and then funded centrally.

**Budget Implications for the Institute-as-Broker Model:**

It is expected that all mental health related research initiatives would be funded competitively through the centralized peer review process and a finite, segregated pool of “mental health research” funding as such, would not exist. Research funding would be commensurate with the level of success of investigator-driven and program-driven grants awarded through the centralized peer review process. In this way, mental health funding could actually expand with the increasing capacity of mental health researchers and the increasing recognition of the importance of mental health problems. A comparatively modest budget would be required to support the various brokerage and development functions and the salaries of the core institute staff (who may be located in different parts of the country). Staff would include:

- A full-time Scientific Director who would take the leadership role in all aspects of the Mental Health Research Institute, maintain Institute accountability, participate in centralized administrative functions (as appropriate), participate in the development of innovative funding programs designed to meet the mandate and mission of the Mental Health Research Institute, and create linkages with various research communities;

- A full-time Associate to the Scientific Director who would assist the Scientific Director in all aspects of Institute functioning, but particularly with respect to capacity building and creating and maintaining appropriate liaisons between researcher, decision-maker, consumer, and other stakeholder communities (likely requiring extensive travel through Canada); and

- Full-time clerical support commensurate with the demands of the emerging roles of the Scientific Director and Associate to the Scientific Director.
**Peer Review Process:**

We propose a two-tiered review process. The first tier would be a merit review and priority ranking of projects undertaken at the level of the Institute. It would include extensive input from stakeholder groups such as the consumer community (through national advocacy groups such as the Canadian Alliance for Mental Illness and Mental Health), end-users of research (including provincial and local policy-makers), mental health researchers, and bio-ethicists. Priority rankings would be assigned according to the relevance and potential impact of the project with respect to national mental health research priorities, and for how well the proposed research met the specific goals of Institute-initiated programs. The second tier would be the formal scientific peer-review process undertaken as part of the centralized functions of the Canadian Institutes of Health Research. In order to ensure that scientific reviewers were appropriately knowledgeable about mental health research, the Institute would take a leadership role in recruiting appropriate nationally and internationally renowned mental health scientists to serve on peer-review committees, and participate in all aspects of committee development to facilitate the appropriate review of mental health research.

It is expected that an appropriate process will be created to include both Institute-based merit review rankings and peer-reviewed scientific rankings in the final determination of funding. Projects that were considered to be highly meritorious with respect to potential impact and national relevance, but failed to pass the peer review process, would be prime candidates for Institute-funded technical support and capacity building. This may include funding expert consultations to assist investigators to improve the scientific merit of their project or by helping investigators enlarge their research teams to include appropriate expertise. In this way the Institute-based merit review process is intended to be used constructively to build mental health research capacity and competitiveness in Canada.
Institute Accountability:

It is expected that the Institute would participate in an externally conducted review and evaluation of its functions, not unlike an accreditation review. The purpose of the review would be to: seek the advice of international mental health experts regarding Institute functioning; undergo an objective review of activities to ensure that the Institute and its initiatives were meeting their stated goals and that these remained relevant; identify internal and external barriers that might exist with respect to realizing Institute objectives; and make recommendations for future activities. We would expect that such a review would be orchestrated and funded centrally as part of the standard operating procedures for the Canadian Institutes of Health Research but that the Institute would participate in the selection of appropriate external reviewers. In this way, Institutes could be reaffirmed or re-designated on a routine basis (such as every five years). It would be expected that Institutes that were considered to have failed in their mandate would not be re-designated.

Secondly, it is expected that all grant-holders would be accountable to the Canadian Institutes of Health Research for their funding and that this would be managed at the central level by knowledgeable staff. However, particularly in the case of special Institute-related initiatives, there should be some mechanism so that Institute staff may play an integral role in the accountability process. This would be particularly important in the case of longer-term programs of mental health research that may undergo periodic review for renewal.

Scope of Institute Activities:

Mental Illness and Mental Health:

The historical challenge for the mental health field has been to maintain an appropriate balance between activities directed toward mental illness and those directed toward mental health, since these are qualitatively distinct fields. In the service delivery arena, broadening concepts of mental health and increased attention to social problems
have inadvertently shifted funds away from those with serious and persistent mental illnesses such as schizophrenia or major affective disorders. As we now try to redress this imbalance, those who are suffering from emotional, behavioural, or psychological conditions that may not meet the criteria for a mental disorder but which are equally distressing or disabling, worry that they will “fall through the cracks” of a system geared only toward the needs of the seriously mentally ill. This issue has been raised within the context of women’s mental health (see Morrow and Chappell, 1999) but could equally be raised with respect to other socio-cultural groups such as aboriginal or immigrant health. Thus, it will be important to establish national priorities that reflect a balance between mental health and mental illness related concerns with broad input from stakeholders in each of these communities.

Addictions:

A separate issue is the overlap between mental health and addictions and the extent to which the country could or should support separate Institutes in these two areas. The spectrum of mental disorders as defined in official diagnostic nomenclature such as the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV (American Psychiatric Association, 1994), does not segregate addictions from the general field of psychiatric inquiry. It includes a wide range of addictive behaviours including alcohol use/abuse; drug use/abuse; gambling; eating disorders; and certain sexual disorders. At the population level, there is considerable overlap between substance abuse and other major mental disorders. For example, data from US surveys using the DSM definition of mental disorders indicate that up to 28% of all Americans experience a psychiatric disorder during any given year. If individuals having only addictive disorders are eliminated from this figure, the one-year prevalence rate for a mental disorder is still 22% (Leaf, 1994). In the Epidemiologic Catchment Area surveys in the United States (the largest community psychiatric studies completed to date), 52% of those with a history of alcohol abuse and 75% of those with a history of drug abuse also met the criteria for another psychiatric disorder. As alcohol and drugs are often used to self-medicate symptoms of depression and anxiety, these disorders frequently co-occurred (Kessler, 1995). Finally, alcohol is also a significant factor in suicide. In Manitoba, for example, alcohol was involved in 50% of all youth suicides between the age of 15 and 24 years.
Alcohol seems to play a role in the susceptibility to suicide as well as increasing the likelihood of precipitating factors, such as arguments, occurring (Sigurdson, Staley, Matas, Hildahl, & Squair, 1994).

There is considerable overlap between major mental illnesses and addictions and, therefore, the interests of these two research communities. Whatever the ultimate configuration of Institutes, a multi-disciplinary integrative approach to research and service delivery in these fields will remain a priority. The recent amalgamation of several psychiatric and addictions services (including their respective research centres) into the Centre for Addictions and Mental Health in Toronto is an example of the growing recognition of the need for integrated research and delivery networks. In keeping with this trend, mental illness, mental health, and addictions issues could, and perhaps should, be amalgamated under a single Institute structure. If this were to occur, then we would recommend that a second Associate Scientific Director position be created (with appropriate clerical support) to undertake the liaison and capacity building activities appropriate to the addictions field. If the Governing Council designates separate Institutes of Mental Health and Addictions, then the Mental Health Institute would devote special attention to bridging activities (such as developing joint capacity-building or research initiatives), to ensure that these fields are not segregated from each other.

≈ Conclusions and Recommendations:

In consideration of:

- The bio-psycho-social nature of most mental health related problems and the resulting opportunities for building transformative research,
- The high burden of morbidity and mortality caused by mental health related problems,
- Their associated social and economic costs,
The need for national research priorities designed to use funds cost-effectively to target the most important public health challenges,

The importance of developing a foundation of health system evidence to guide mental health reforms,

The need to build both research capacity and uptake of research findings by decision-makers and consumers, and

The need to incorporate a broad range of consumers and stakeholders in the mental health research process,

We strongly recommend that:

- A Mental Health Research Institute be created under the auspices of the Canadian Institutes of Health Research.

Further we propose that the Mental Health Research Institute:

- operate in a broker capacity between the Canadian Institutes of Health Research Governing Council and central administration, funders, researchers, decision-makers, consumers, and other stakeholder groups to promote integrative and transformative research;

- participate in centralized peer review processes and undertake an Institute-based merit review of all mental health related research,

- directly fund capacity-building initiatives in the form of workshops, networks, and consortia;

- take a leadership role in the development and funding of a national mental health research agenda; and

- advocate for mental health research priorities through the development of innovative programs that could be funded under the aegis of the Canadian Institutes of Health Research.
References:


Appendix A

The following table contains the names and organizational affiliations of key stakeholders who attended the National Consultation Workshop funded through the Mental Health Design Grant. They represent all facets of the mental health research, provider, consumer, and policy communities and reflect a full spectrum of bench to bedside; molecule to community. Although not considered to be an exhaustive list of the human capital available in Canada to conduct transformative mental health research, they, and the organizations they represent, could provide a nucleus for networking and development activities contemplated under the proposed Mental Health Research Institute.

<table>
<thead>
<tr>
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