HEATHER MACIVOR

Question Period:
More sound than substance? (Pg 3)

PATRICIA BELL

Investing in Childhood Education and Care:
Questions for Martha Friendly (Pg 5)

KEN NORMAN AND JOHN D. WHYTE

Is Controlling Hate Speech too Controlling?:
An examination of hate-law jurisprudence (Pg 8)

LEE WARD

The Legacy of Martin Luther King Jr.:
Forty years on (Pg 10)

GREGORY P. MARCHILDON

Serving the Public Policy Needs of Saskatchewan: A provincial solution (Pg 12)

JIM MARSHALL

A Recession in the Wings?: If there is a downturn, will it affect all of us? (Pg 14)

SPECIAL SECTION - MENTAL HEALTH PLANNING AND POLICY: JOHN CONWAY

Transformative Change in Mental Health (Pg 16)  CLAUDE ROCAN - Protecting and Promoting Positive Mental Health (Pg 17)

PATRICIA J. MARTENS - "First, do no harm" (Pg 19)  JOSEPH KLUGER - The Most Important Policy and Program Objectives for Mental Health Planners in Saskatchewan (Pg 21)  DAVE HEDLUND - Mental Health and What We Should Do as Planners (Pg 23)

MEETING THE DEMAND FOR CHILDHOOD EDUCATION AND CARE IN SASKATCHEWAN
Last issue, I reflected a little on the meaning of the word “dialogue.” Trying to define the word “policy” much less reflecting on its deeper meanings and nuances is much more difficult in part because almost every policy practitioner has his or her own intuitive or common sense definition of the word. Scholars have hardly helped matters. I have seen entire books on public policy in which the authors do not once attempt to define what they mean by policy. This can cause serious problems in conversations about what constitutes effective public policy. We end up arguing in circles hardly realizing that our definitions of “policy” are at least partially incompatible. The stakes are high for those charged with the responsibility to initiate and implement public policy today. They are also high for those of us in the business of judging the past, keeping in mind that we ultimately assess governments on their public policy legacies – that is, what individual administrations have bequeathed to subsequent generations.

Because Canadians are familiar with the Westminster Parliamentary system of government, and the adversarial political party system that underpins it, we are much better at identifying differing, and often conflicting, policy objectives. We generally know better than to equate “effective” policy objectives with what we personally consider “good” policy objectives based upon our individual ideological and political proclivities and beliefs. And we generally know what we mean by “effective” – achieving a defined set of substantive objectives while minimizing resources and negative knock-on effects.

But what do we mean by policy? In my article on “Serving the Public Policy Needs of Saskatchewan” in this issue, I define public policy as “the systematic laying out of government’s goals combined with the practical measures proposed to achieve those goals.” No doubt, many of you can think of a better way of defining public policy but my main point is that we would benefit from being as explicit as possible about what we mean by “policy” in any discussion of what constitutes effective or good public policy.

**Director’s Notes**

**Defining the word “policy”**

BY GREGORY P. MARCHILDON, DIRECTOR, SIPP

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QUESTION PERIOD

More sound than substance?

BY HEATHER MACIVOR, ASSOCIATE PROFESSOR OF POLITICAL SCIENCE, UNIVERSITY OF WINDSOR

While Question Period may once have been a crucial mechanism of accountability, it has degenerated into a pointless verbal brawl which brings the entire parliamentary system into disrepute. Can the original practice of Question Period be restored or is it time to say goodbye?

There is a growing public perception that the behaviour of Canada’s current Members of Parliament (MPs) is unprecedentedly awful. This notion is understandable, but overstated. In the nineteenth century, Commons debates were sometimes marred by drunken buffoonery – and occasionally by physical altercations. Today’s MPs are a remarkably sober and peaceful lot compared to their 19th-century predecessors.

If it appears otherwise, the main reason is the daily Question Period (QP). Party leaders posture and point fingers, spewing righteous outrage at each other like divorcing spouses. When government ministers aren’t stonewalling, they’re hurling accusations back at their tormentors. The unedifying spectacle resembles that great oxymoron “reality television”: the ostensibly spontaneous remarks are scripted; the conflicts are staged for the cameras; and the vapidity of the dialogue hurts the brain (while the volume assaults the ears). While QP may once have been a crucial mechanism of accountability, it has degenerated into a pointless verbal brawl which brings the entire parliamentary system into disrepute.

The first recorded instance of a British parliamentarian questioning a minister on a matter of public interest occurred in the House of Lords in 1721; within a short time, the practice spread to the House of Commons. The practice of setting aside time for MPs to question members of the government on public business was established around 1850, and by 1902, the Standing Orders prescribed a daily period when ministers would give oral replies to written questions on the Notice Paper.

Questions to the prime minister (PM) were lumped in with the rest, which often meant that the time for questions had expired before the PM was called on to reply. By the middle of the twentieth century, specific times were set aside for questions to the PM. In 1953, as a concession to Winston Churchill’s declining health, his availability was limited to 15-minute periods on Tuesdays and Thursdays; the custom was institutionalized in 1961. Shortly after taking power in 1997, Tony Blair announced that he would only be available for one 30-minute session on Wednesday afternoons.

Until recently, British MPs had to provide written notice of oral questions. The rules have always been looser in Canada: MPs could dispense with written notice if they inquired about “very urgent and important matters of public concern.” By the late 1950s, QP consumed up to one-third of the sitting day. The Standing Orders were revised in 1964 to set time limits on QP so the House could conduct other parliamentary business. Today, 45 minutes of every sitting day are devoted to oral questions.

Canada would do well to follow the British example, and further reduce the time allotted to QP. Today, MPs spend far less time in the House than they did 40 years ago. The work of Standing and Legislative Committees has mushroomed, along with the volume of constituency casework. Once QP gets underway, few opposition MPs ask substantive questions about the vital issues of the day. Prime Minister Stephen Harper and the Government House Leader Peter Van Loan routinely treat questions (and questioners) with contempt. There must be a more productive use for three and a half hours of House time each week.

Nor is this the only waste of time associated with QP. The opposition caucuses meet first thing in the morning to search the previous night’s news coverage for sticks with which to beat the government. The MPs, the caucuses’ research staff, and the leaders’ offices spend the rest of the morning working on questions. There is a final meeting just before QP to finalize the details; then the Speaker is informed of the order and targets of questioning. Meanwhile, the political staff in the Prime Minister’s Office and the

Question Period Cont’d on PAGE 4
members with respect brings out the best in his or her MPs; a nasty and disrespectful leader brings out the worst.

This effect is observable in Ottawa. Prime Minister Harper sets a poor example by his occasional indulgence in vicious *ad hominem* attacks and his refusal to acknowledge even the smallest misstep. He is not the first PM to treat the opposition with disdain (Trudeau’s “fuddle-duddle” remark leaps to mind), but his actions have exacerbated the partisan rancour which bedevils the Commons. He is surely intelligent enough to understand that more statesmanlike behaviour would help him to win a majority in the next election, but the perverse incentives of QP seem to overwhelm his better judgment.

Any Canadian who has watched PM’s Question Time in the British Parliament must yearn for its comparative eloquence and decorum. We still have much to learn from the “Mother of Parliaments”, starting with a more sensible approach to oral questions.

ENDNOTES


5. Riddell, p. 824.


INVESTING IN CHILDHOOD EDUCATION AND CARE

Questions for Martha Friendly

BY PATRICIA BELL, ADJUNCT PROFESSOR, UNIVERSITY OF REGINA, SCHOOL OF JOURNALISM

The Saskatchewan Party Government, in its 2008-09 budget, has allocated funding for 500 new child care spaces. According to a new research report “Child Care Space Statistics 2007” released by the Childcare Resource and Research Unit, this comes at a time when the pace of expansion of regulated child care has slowed in provinces across Canada. Although Saskatchewan was the early leader in universal health care, it’s nowhere near being a leader when it comes to an early learning and child care system, says the report’s author Martha Friendly, a child care researcher for 30 years, and executive director of the Childcare Resource and Research Unit, formerly part of the University of Toronto. In 2005, Ms. Friendly researched and wrote a Public Policy Paper for SIPP entitled “Early Learning and Child Care in Saskatchewan: Past, Present and Future”. Now she takes another look at the need for robust public policy on this issue.

You’ve been tracking the data and reporting the trends across Canada every three years since 1992. It seems that although the proportion of Saskatchewan children in regulated child care has moved up to 5.9%, it’s still only one-third of the national average.

Our new report covers the period April 2006 - March 2007. So it doesn’t include anything done since then. What we saw overall was the smallest increase in spaces for Canada as a whole in many years. Saskatchewan, with only 138 additional spaces in 2006, had the smallest increase in Canada – except for the territories – and it was already starting from an extremely low base.

What was the base?
Since 1992, Saskatchewan has added only 2,400 new, regulated spaces. That’s a long time and not a lot of spaces across the whole age span of birth to 12 years – and they weren’t necessarily funded in any way.

What stands out about Saskatchewan’s provision of child care?
Well, I’m trying to put Saskatchewan in perspective. While all of the provinces have fairly limited child care, Saskatchewan has the lowest coverage – that is, the ratio of spaces to children. As well, the subsidy system is quite restrictive, so access to the existing spaces is very difficult for low income families. Like the rest of Canada, development of child care is ad hoc and market-driven, which keeps access even more uneven. As well, Saskatchewan has a large proportion of Aboriginal people – a very disadvantaged population, many of whom live in urban centres with no culturally specific programs.

Saskatchewan allocated $22.8 million to regulated child care in 2005-06. Who is being served?
There’s always been an assertion that child care is targeted at the low-income population, but this population is far from being served. In 2006, I looked at how many children are subsidized and how many are living below the poverty line and there’s quite a big discrepancy. As there is a very small supply of spaces, I wonder where all the children with mothers who are in the workforce or in education and training are; there is no data on that.

You note as a point of contrast that Manitoba, with a relatively similar child population, demographics and prairie traditions, spent $86.3 million on regulated child care in 2005-06. In 1992, it spent $42.2 million. Given the similarities, what are some of the differences in how Manitoba and Saskatchewan have approached the issue of providing child care?
If you put the populations side by side, there are so many similarities yet the coverage and the accessibility to low income families through provision of subsidies is considerably higher in Manitoba, the Early Childhood Education
training requirements are higher, and there’s a much more active child care community which works closely with government. (I’ve been told) that an explanation could be that although Manitoba is also agrarian, it had more of an industrial base and always had a strong labour movement.

Saskatchewan has one of the higher provincial labour force participation rates for mothers with young children. It’s 77% for those whose youngest child is between three and five. For parents coping with the day-to-day stress of home and work place responsibilities, it’s not easy to find time to lobby for more child care as Ontario parents did in the 1970s. They shouldn’t have to – this should be a public good, with governments playing a key role. The biggest increases of child care in Ontario occurred when there was a government initiative to develop these spaces. In the 1980s the David Peterson (Liberal) government said they would actively support child care and that’s when the non-profit sector really grew, continuing when the NDP came in, in 1990. The thing I want to stress is that unless government actively supports expansion and improving quality, it won’t happen. If there is to be a system, it has to be substantially funded by government and led by government. Otherwise it won’t be a system and it won’t flourish. Parents in the work force aren’t leaving their kids alone. They’re putting them somewhere. But the question remains: “Is this a good early childhood education experience for the child?” This is a policy issue the provincial government has to address.

What about the pre-kindergarten program?
Saskatchewan has pre-kindergarten as one of the Ministry of Education programs. These were set up for very disadvantaged children, but the very disadvantaged children whose mothers are working or in training programs often can’t get to them because these aren’t full-day programs. The child care program has moved to the Ministry of Education as well. That’s a good move and part of a trend in many countries to bring good quality child care and early learning together. But what happens next to blend learning and care together? If the spaces aren’t there, it’s not early learning. If it’s not good quality, it’s hard to call it early childhood education. And if they remain separate programs, it’s hard for children and parents.

Why are you concerned that early childhood education and child care be recognized as a whole and not as two distinct areas of a young child’s life?
Today most experts agree that good quality child care is early childhood education and that splitting up a child’s day into “learning” and “non learning” parts is a misunderstanding of how young children learn. A three-year-old is a three-year-old, and children are learning all the time. Young children need care because they are small children and that means everything from physical care to emotional care. You really can’t separate these, especially in a long day. I think people who don’t know about early childhood education think of it as children repeating the alphabet or getting a head start on reading. Yes, books are a part of early learning, but high quality early learning programs are those aimed at the whole child, not merely the school readiness part, and intertwined between learning and care.

With Saskatchewan’s economic boom luring more people, how might the province invest in helping working parents with the care and education of young children?
Right now the province doesn’t have a mechanism for developing child care or maintaining it well. It’s a policy exercise: what is it that you want and how are
you going to get there? We’re talking about a 10 or 12-year plan with goals and benchmarks. If one goal is to help low-income people succeed in employment, you have to think about whether there is something else you could be doing. If 15 years from now a goal is blended early childhood education and care and a space available for every child, then you need to identify that as a goal and then say how you are going to meet it.

In 2005, the former federal Liberal government signed agreements with each province and pledged money for the beginning phase of a universal child care program. Why is there such diversity across the country?

I think that it is less about diversity than that each province has jurisdictional responsibility for social programs that is jealously guarded. In all parts of Canada, children need good quality early childhood education and parents need good child care while they’re at work – [there’s] not much diversity there. The federal government program under Paul Martin was to have been a catalyst and every province was required to develop a plan. When the Conservative government pulled out the money, some of the provinces continued to try to advance their plans. But it won’t really go anywhere nationwide without substantial federal backing.

What do you see as Ottawa’s role?
I think that Ottawa needs to take a leadership role as the federal government did in ensuring that Medicare became a national program. There is no reason to let provinces off the hook, but the federal government should facilitate and enhance this discussion. This includes providing substantial funding and working with the provinces to develop an overarching policy framework. Without the federal government, high quality early childhood education and care programs will remain few and far between and outside the reach of most Canadian families. There’s no reason for this to be so in any part of Canada – we’re a wealthy country, much wealthier than countries that have much better developed early childhood education and care programs.

What are important steps to take now?
We need dialogue among the provinces and with the community. We also need to improve data and monitoring. That’s critical.

Winner of the 2008 Donner Prize

The People’s House of Commons: Theories of Democracy in Contention by David E. Smith

This award-winning book examines the major questions of parliamentary governance facing Canadians today. Published by the University of Toronto Press, The People’s House of Commons outlines the historical foundations of Canadian parliamentary, constitutional and electoral democracy, and considers the ramifications of many of the changes currently being proposed to Canada’s political system.

David E. Smith currently conducts research and teaches at the University of Regina as Senior Policy Fellow at the Saskatchewan Institute of Public Policy.

“Smith’s scholarship is impeccable and the result of his labours is a thorough and thoughtful review of the House of Commons as the pre-eminent institution of Canada’s parliamentary democracy, and of the criticisms and concerns that have been expressed in relation to it.”

~ Jury Chairman Grant Reuber

Ms. Martha Friendly, Child Care Researcher and Executive Director of the Childcare Resource and Research Unit

Ms. Martha Friendly, Child Care Researcher and Executive Director of the Childcare Resource and Research Unit
IS CONTROLLING HATE SPEECH TOO CONTROLLING?
An examination of hate-law jurisprudence

BY KEN NORMAN, PROFESSOR OF LAW, UNIVERSITY OF SASKATCHEWAN AND JOHN WHYTE, LAW FOUNDATION OF SASKATCHEWAN

VISITING PROFESSOR, UNIVERSITY OF SASKATCHEWAN

In light of the national attention paid in early April to David Ahenakew and Tom Lukiwski for their openly expressed anti-Jewish and anti-gay views, it might have seemed as if Saskatchewan had become the national capital of hate speech. This is probably unfair; expressing intense dislike of some minorities is, sadly, experienced in too many communities in Canada. However, Saskatchewan seems to have become the capital of hate-law jurisprudence. Recently, the Saskatchewan Court of Appeal issued judgments in Ahenakew (reversing a conviction under the Criminal Code for promoting hatred against Jews), Owens (reversing a human rights inquiry ruling that certain published material exposed homosexuals to hatred in violation of the provincial human rights code), and Whatcott (setting aside the discipline of a member by a professional association for unprofessional conduct in maligning Planned Parenthood).

As these cases show, a number of regulatory instruments are used in Canada to control hate speech. The two most direct are a Criminal Code offense that requires proof of willful public promotion of hatred for groups and human rights legislation that proscribes expression that is likely to expose identified minorities to hatred.

Not surprisingly, these restrictions on speech have given rise to a considerable national controversy over both the wisdom of limiting any speech, even hateful speech, and the degree to which the constitutional protection of free expression in the Charter of Rights should either limit or strike down restrictions on expressing hatred for identifiable groups.

Defenders of regulating hate speech make two major points. First, some, like American critic Stanley Fish, argue that it is socially and politically self-destructive and ahistorical not to understand that political communities inevitably place limits on speech. The speech that is invariably limited is the speech that turns basic social and political presuppositions inside out, that creates existential crises, and that is designed to undermine the political order. This might include promoting such things as political overthrow, the radical exclusion (even slavery or death) of certain vulnerable groups, or forced fidelity to a religious belief. Fish likes to point out that John Milton’s famous defense of free speech, Areopagitica, notes: “I mean not tolerated popery and open superstition, which … should be extirpate[d] …” Fish’s point is that some ideas so destabilize fundamental conceptions of political normalcy, of the good, that we cannot tolerate them. Applying this to hate speech, Canada is founded on the strongest commitment to inclusion for minority communities, as expressed by provisions of the Constitution Act, 1867 and by ss. 15 and 27 of the Charter, and as reflected in our international treaty commitments (Article 4 of the CERD and Article 20 of the ICCPR).

Defenders of free speech do not so much resort to principles … as offer the pragmatic view that the best way to tame hate is to allow it to come into the open and then refute it or, since the idea of refutation is inapplicable to most hate speech, expose it to ridicule.

Second, we normally see speech as just the presentation of ideas that may, of course, become a basis for harmful action but is not itself action. But, in fact, hate speech is performative which means that it acts directly on the world to change it. Wishing disease on, or damnation for, homosexuals or calling Jews a disease are forms of banishment — they impose an immediate loss of the senses of belonging and legitimacy. We ought not to allow this injury.
Defenders of free speech do not so much resort to principles (open speech is the surest path to truth; it helps people form their thoughts and values and is, therefore, important to self-realization and essential to democratic political processes) as offer the pragmatic view that the best way to tame hate is to allow it to come into the open and then refute it or, since the idea of refutation is inapplicable to most hate speech, expose it to ridicule. If those attacked by hate speech feel vulnerable for a while, they will be strengthened by the forceful rejection of that hate. A further pragmatic argument was made by Justice McLachlin in her dissenting opinion in *Keegstra* (a decision that upheld the conviction of a school teacher for hate speech in instructing his students on the “evil qualities of Jews”). She saw prosecutions for hate speech as serving to magnify hate through the broadcasting effect of trials. Of course, these pragmatic observations conflict; it is not possible to obtain broad public disavowal of hateful speech unless it is widely disseminated.

Regulation of hate speech is also attacked on the basis of speech absolutism – controlling some speech because it is socially undesirable runs the unacceptable risk of regulating every sort of speech that governments find troublesome. For this reason we should live without restrictions on speech. Canadian civil libertarian Alan Borovoy argues that hate speech law “is likely to catch the wrong people.” He reflects the view of Justice Robert Jackson, of the United States Supreme Court, who said, “If there is any fixed star in our constitutional constellation, it is that no official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matter of opinion…”

Finally, critics of hate speech regulation contend that statutory descriptions are never more precise than “hatred”, “ridicule” or “contempt” and, it is claimed, these words are too vague to give speakers clear warning of what they cannot say. This vagueness limits – or chills – speech, thereby weakening the constitutional protection of speech. Chief Justice Dickson in two cases, *Keegstra* and *Taylor*, attempted to address this criticism through creating a judicial standard for both the Criminal Code’s hate speech provision and the human rights legislation that limits regulation to the most extreme forms of vilification and detestation.

As for the Saskatchewan Court of Appeal’s recent decisions, only *Owens* engages in these competing ideas over speech regulation. The *Ahenakew* decision was based on the prosecution failing to prove beyond a reasonable doubt that

David Ahenakew’s purpose was to promote hatred. In *Whatcott*, the court concluded that anti-abortion campaigning, no matter how extreme or wrong its claims, did not bear on William Whatcott’s professionalism as a licensed practical nurse. In *Owens*, the court felt that the precise form of expressing dislike of homosexuals in an advertisement did not amount to hatred. According to the court, the “forbidden” symbol in the advertisement (a circle with a slash) over two stick men was ambiguous and did not necessarily express hatred of homosexuals. Furthermore, the reproduction of four Bible passages (including Leviticus’ “If a man lies with a man … [t]hey must be put to death”) should not be taken at face value but should be seen as “ancient texts” rather than a contemporary publication. Of course, the advertisement was contemporary and the hatred implied was current and immediate.

At the heart of the court’s decision, however, was its characterization of the advertisement’s salience in “an ongoing national debate about how Canadian legal and constitutional regimes should or should not accommodate sexual identities.” The court said that the advertisement “had the character of a position advanced in a continuing public policy debate rather than the character of hatred or ill will.” In other words, the advertisement was regarded as political speech, not hate speech, and as such it deserved constitutional protection. While this depiction is, perhaps, understandable, it creates classifications of speech and time that undoubtedly abridge the established Canadian principle that our Constitution does not protect speech that in its expression of hatred for others injures them.
THE LEGACY OF MARTIN LUTHER KING JR.

Four decades have passed since the assassination of civil rights leader Martin Luther King Jr. It is, of course, difficult to assess the impact of such an important and complex figure, and yet we can conclude with some degree of confidence that America is still reverberating from the aftershocks of events that occurred a half-century ago. Dr. King’s effect on American politics was transformative and manifold.

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ommemorations of Martin Luther King’s assassination on April 4, 1968, have become an important annual ritual of American public life. This year’s commemoration of the life and death of the slain civil rights leader, cut down at the age of 39, is particularly poignant given Senator Obama’s historic candidacy and, as Juan Williams recently observed, this “is the first time he has been gone longer than he lived.” Now with the benefit of four decades of experience, what can we say about Dr. King’s legacy?

It is, of course, difficult to assess the impact of such an important and complex figure, and yet we can conclude with some degree of confidence that America is still reverberating from the aftershocks of events that occurred a half-century ago. Dr. King’s effect on American politics was transformative and manifold. On one level, his legacy is inseparable from the legislative achievements embodied by the Civil Rights Act of 1964 and the Voting Rights Act of 1965. While the first blow to the legal apparatus supporting segregation in the southern states may have come from the U.S. Supreme Court’s historic decision in the 1954 case of Brown v. Board of Education, it is obvious that the complete dismantling of the vast system of segregation and legal discrimination in the South would have been unthinkable without Dr. King’s leadership and the inspiration he provided for the federal action that arguably completed the constitutional revolution begun a century before in the Civil War.

By transforming the South, Dr. King also played an indirect role in dramatically altering America’s two-party system. De-segregation and legal protection for minority voting rights jolted the tectonic plates of the American electoral process by realigning the rigid party blocs that had remained virtually unmoved for over 100 years. With the passage of the Civil Rights and Voting Rights Acts in the mid-1960s, southern white conservative voters, once the bedrock of the Democratic Party, began to migrate at first tentatively, and then eventually in a deluge, towards the Republican Party, long despised as the party of Lincoln and abolition. For two generations in presidential elections, and more recently at practically all levels of government, the “solid South” has come to mean Republican dominance in that region of the country.

However, Dr. King’s impact on American politics cannot be determined solely, or even primarily, on the level of parties and legislation. A more fundamental legacy has to do with his crucial role as one of the chief architects of the new American public philosophy that emerged in the post-war period. Dr. King understood perhaps more clearly than any of his peers the power that national television and print media possessed to challenge local and regional practices.

Dr. King understood perhaps more clearly than any of his peers the power that national television and print media possessed to challenge local and regional practices by casting them under the searing spotlight of what was at the time an inchoate, but unmistakable, national consciousness about the problem of racial discrimination. As he proclaimed in the magisterial Letter from a Birmingham City Jail, in modern America: “Injustice anywhere is a threat to justice everywhere … Anyone who lives inside the United States can never be considered an outsider anywhere in this country.” Under Dr. King’s leadership the civil rights movement embraced the information technology revolution and effectively nationalized the cause of civil rights by making the injustice of segregation palpable to many millions of Americans, not to mention an international audience, far removed from the South. The great African-American sociologist W.E.B. Dubois spoke at the start of the last century of the “veil” marking the “color-line”
separating white and black America. Dr. King, armed with unparalleled rhetorical ability and the revolutionary strategy of civil disobedience, cast aside the veil as no other figure prior in American history, and thus allowed Americans of both communities to peer towards paths of empathy and mutual understanding.

Dr. King and the civil rights movement also changed America’s political culture and its liberal tradition by deepening and broadening the progressive movement in the country. Franklin Roosevelt created the modern American state by increasing the power of the national government and by drafting working-class whites and immigrant communities into a stable governing coalition. However, it was left to Martin Luther King Jr. to modernize the reactionary South and to begin the process of integrating and incorporating the African-American community into the post-war liberal consensus that would provide long-term, if not always deep, public support for affirmative action programs and other remedial measures. Dr. King’s words and example created a generation of middle-class baby boomers for whom commitment to civil rights would be a defining characteristic of their political values. For these young white liberals attending elite law schools and Ivy League universities in the 1960s and 70s, including many current leaders of the Democratic Party, the civil rights movement was the very embodiment of a cause greater than oneself.

This is not to suggest that Dr. King’s legacy is simply transformational. He faced setbacks in his lifetime and championed causes such as opposition to the Vietnam War, and militarism more generally, that failed by and large to resonate with the broader American public to the same degree as the cause of civil rights. His cherished Campaign Against Poverty is probably the least successful aspect of his legacy. Today more than 40 years after his death nearly 25% of African-Americans live in poverty, a rate higher than any other group in the nation. The scourges of unemployment, crime, drugs and educational disparities still disproportionately affect the African-American community, and thus undermine the principle of equal opportunity at its very foundation.

Perhaps Dr. King’s most lasting and profound legacy is the impact he had on the soul of American politics. “Soul” is a difficult concept to quantify or fit into the paradigms of standard public policy analysis. But then again Dr. King was not a political scientist; he was not even strictly speaking a politician.

The transformation of the soul of American politics can be gauged as much by what did not happen in race relations, as the concrete measures that did. As Senator Obama’s recent speech on race, delivered in the wake of the Rev. Wright controversy, plainly reveals, Dr. King’s hopeful message of integration and reconciliation is the touchstone for any meaningful discussion of race in America today. When we reflect upon Dr. King’s legacy, it is good to recall that this was not inevitable. It is easy now to forget the polarization and extreme positions that once threatened to dominate the future of race relations. Dr. King emerged at a time when racial divisions seemed poised to harden into irreconcilable and conflicting positions. But for Dr. King’s message of hope, the race debate in modern America may have become inescapably captive to the most extreme voices in the polity – to the hatred of white supremacists, on the one hand, and to what Dr. King called the “frightening racial nightmare” of militant black nationalism, on the other. Dr. King’s moderate and humane appeal to “non-violent direct action” presented the struggle for racial equality in America as a movement that never lost sight of the need to establish and nurture the conditions for future peace and reconciliation. He more than any other American leader past or present defined the parameters for legitimate debate about racial justice, and provided the civil rights movement with an unshakable and inclusive goal firmly planted in the best tradition of American political ideals.

For the fact that extreme and exclusionary arguments about race are no longer publicly defensible positions in American political life today, all Americans can be thankful for the legacy of Martin Luther King Jr. ❯

ENDNOTES
SERVING THE PUBLIC POLICY NEEDS OF SASKATCHEWAN

A provincial solution

BY GREGORY P. MARCHILDON, DIRECTOR, SIPP

Saskatchewan is seen as a leader in the development and execution of good public policy. Over the last 50 years the quality of the province's public policy and public administration has changed. During the last decade, however, Saskatchewan has moved toward creating an innovative provincial school of public policy to bridge the gap between scholars and policy practitioners.

Defining what is meant by “public policy” is a tricky business. If public policy means anything that is done by a government or other democratically empowered public authority, the phrase means everything and therefore nothing. I prefer a narrower but more concrete definition: the systematic laying out of government’s goals combined with the practical measures proposed to achieve those goals.1

In this definition, good public policy requires at least two things. The first is effective design which, in turn, requires a clear understanding of the problem to be addressed and the causal factors producing a given outcome. The second is effective implementation which necessitates an intimate understanding of public administration, management, governance and leadership. The first is greatly assisted by understanding the content and methods of the social sciences, law and history, while the second can be supported by a systematic training in public administration and management.

Saskatchewan is seen as a leader in the development and execution of good public policy. Medicare is the historical example that comes readily to mind, but there are a number of other past policies in which the province was a national leader. However, few observers say, as they often did 50 years ago, that Saskatchewan stands head and shoulders above other provinces in the quality of its public policy and its public administration. Some might say that hardly matters anymore and that perhaps we can buy our way out of problems given the new strength of the provincial economy. But we know that booms can be short-lived and are hardly a substitute for effective social, environmental and economic policy.

In the past, the province relied heavily on attracting externally educated and trained talent to the province. There were exceptions such as the famed Budget Bureau which drew roughly half of its new recruits from the University of Saskatchewan, the rest coming from central Canadian universities. The degrees were in Arts and Sciences (political science or economics, most commonly) or in Commerce. With the establishment of the University of Regina in the 1970s came a generic degree in administration and another source of indigenous talent for the public service, although the majority of public servants with graduate policy degrees hired by the provincial government were MPA students from Queen’s and Carleton.

Few observers say, as they often did 50 years ago, that Saskatchewan stands head and shoulders above other provinces in the quality of its public policy and its public administration.

During the past decade, the Saskatchewan Institute of Public Policy (SIPP) has played a major role in serving the public policy needs of the province. SIPP originated with a proposal from a faculty committee at the University of Regina to the Government of Saskatchewan aimed at bridging the gap between scholars and policy practitioners at a time when the committee felt that it was premature to establish a full-fledged school of public policy. But the committee concluded that the time was ripe to establish a policy institute that would become a focal point in stimulating and reshaping policy discourse in the province as well as providing alternative policy advice and consultation to decision-makers.

The provincial government agreed to become a full partner in the SIPP initiative but insisted on the participation, however limited, of the University of Saskatchewan in light of the Johnson Report of 1993 and the subsequent MacKay Report of 1996 urging greater
This is a unique venture, without parallel in Canada. It lives up to the lofty vision and recommendations in the Johnson and MacKay reports. It addresses the main “challenge for both universities” as described by Harold MacKay in 1996; that is “to develop their program changes in a fashion which will, among other things, address any legitimate public concern in respect of (a) the duplication of programs or functions, (b) the perceived lack of cooperation between the two universities, and (c) the ability of the universities to respond to the current internal and external challenges.”

Although the idea may seem logical given the policy needs of the province, there was never any guarantee such an organization would be created. The fact that a broad-based, provincial JSGS now exists speaks to the fact that bold innovation and leadership is not just a relic of the past in Saskatchewan.

In the decade since, SIPP has encouraged the production and dissemination of public policy. Its location in the Gallery Building on College Avenue has offered a neutral ground between government and the academy in which both scholars and policy practitioners could offer their take on numerous policy questions, the majority of which were directly relevant to the province’s policy challenges. Former decision-makers including premiers and ministers rubbed shoulders with public servants and scholars at SIPP’s numerous armchair lectures, seminars and national conferences. When called upon, SIPP provided policy advice to provincial and federal government organizations as well as non-governmental organizations via arm’s-length contracts.

In 2005, the University of Regina finally established the Graduate School of Public Policy. It was renamed the Johnson-Shoyama Graduate School of Public Policy two years later to honour two of Saskatchewan’s greatest public servants as well as use their exemplary careers in the governments of Saskatchewan and Canada to emphasize the connections between policy and administration. The mission of the school was to provide advanced education and training to a new generation of students in order to enrich the policy capacity of the province. From the beginning, it was intended to be a destination school, attracting students from other parts of Canada as well as other countries in the expectation that at least some of these students would make the province their permanent home.

On July 1, 2008, the Johnson-Shoyama Graduate School of Public Policy (JSGS) becomes a tripartite merger involving the existing school at the University of Regina, a new school at the University of Saskatchewan, and the considerable outreach activities of SIPP. In addition, a new activity will be added by the provincial government’s commitment to fund a major executive training program through the provincial JSGS. This new provincial organization has the critical mass to make a major national impact. By virtue of its mandate and resources, the provincial JSGS should become much more than the sum of its critical parts: a two-campus graduate school, an ambitious program of policy outreach, and a centre for public management training.

This is a unique venture, without parallel in Canada. It lives up to the lofty vision and recommendations in the Johnson and MacKay reports. It addresses the main “challenge for both universities” as described by Harold MacKay in 1996; that is “to develop their program changes in a fashion which will, among other things, address any legitimate public concern in respect of (a) the duplication of programs or functions, (b) the perceived lack of cooperation between the two universities, and (c) the ability of the universities to respond to the current internal and external challenges.”

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ENDNOTES
A RECESSION IN THE WINGS?
If there is a downturn, will it affect all of us?

BY JIM MARSHALL, CHIEF ECONOMIST, SIPP

It has been 16 years since Canada’s last recession, and in the past 40 years, the recessions we have seen have not affected everyone equally. This article examines the recessions in Canada and the U.S. in the last four decades and their impact on a regional basis.

Discussion around the possibility of a recession and the implications of such an event has re-emerged in the popular and business media.1 Understandably, this possibility has raised concerns among many about the implications of economic “downturns” for their own personal situation and the economic conditions that surround them.

What is a Recession?
Technically, a recession represents an overall reduction in the quantity of goods and services produced within an economy. Economists suggest that to be declared a “recession” there has to be a decline in the “real” Gross Domestic Product (GDP) or GDP adjusted for price changes in each of at least two successive quarters of a year.

The fluctuations in data are such that the results of one quarter are not considered indicative of a recession or a real reduction in activity and, it should be noted, this is distinct from the oft-reported “slowdown” in economic activity which is a reduction in the rate of growth from the past rather than a reduction in the level of activity from the past.

Why has this come up now?
Much of the current discussion seems to have been spurred by recent forecasts from organizations such as the International Monetary Fund (IMF) which recently predicted that “[t]he U.S. economy will tip into mild recession in 2008.”2 The IMF notes that the U.S. recession is the result of cycles in the housing and financial markets and will not last as long as to result in an overall reduction in output in the U.S. in 2008 or in Canada, either.3

Do recessions in the U.S. and Canada coincide?
Since 1970, the U.S. economy has shown three recessions and one near-recession. The U.S. economy showed negative growth in the last two quarters of 1974 and the first quarter of 1975. There were two quarters of negative growth in 1980 and the last quarter of 1981; the first quarter of 1982 also had negative growth but, notably in this period, between mid-1980 and mid-1982, the U.S. economy had six out of ten quarters with negative growth. About ten years later there were another two consecutive quarters of growth at the end of 1990 and the beginning of 1991.

While there is a common understanding that a recession occurred in 2001 in the U.S., there were three out of five quarters with negative economic growth between the second quarter of 2000 and the third quarter of 2001, but not two quarters in a row.

In summary, it appears there were recessions in the United States in 1973-74, 1980-1982 (off and on), 1990-91, and another near recession in 2000-01.7

In Canada, there was one quarter of negative growth in early 1975 and no further troubles until 1980 when growth was negative in eight quarters out of 11 between mid-1980 and the end of 1982, including six quarters in a row in 1981-82. In 1990, the last three quarters of the years showed negative...
growth in output as did the first quarter of 1991. In 2001, Canada only had negative growth in output in the third quarter of the year.\(^8\)

So it appears that the U.S. recession in the early 1970s was narrowly avoided in Canada while the recessions of the early 1980s and 1990s were both more prolonged in Canada. The near-recession of 2001 was hardly noticeable in Canada, however. There appears to be a coincidence of recessions in the two countries, but they are not linked in terms of severity of impact.

**Are there regionally-different impacts?**

Quarterly GDP data are not collected by province in Canada, making it difficult to examine the impacts of short-lived recession on a regional basis. But, whatever the rate of change in our national economy, it is clear that regional economies are affected differently by different conditions.

A closer examination of the provincial growth rates during the 1991 recession in Canada reveals a wide disparity in impacts across the country as seen in the chart below. While the Canadian economy as a whole had a negative growth of 2.1% in 1991, the provincial economies’ performances ranged from a growth of -3.9% in Ontario to a high of 1.1% growth in Saskatchewan. While it may appear that the western provinces were the ones to escape the recession, Newfoundland also had positive growth in 1991 and New Brunswick had a growth rate exactly at zero for the year.

![Growth in Real GDP by Province, 1991](image)

In the past seven years, the national economic growth rate has always been positive overall for the year, ranging from 1.8% growth in 2001 to 3.1% growth in 2004. Yet, over that same period there has been at least one province with negative growth in four of the seven years.\(^9\)

**Summary**

While there is growing concern about the possibility of a recession in North America, following the collapse of consumer credit and the other banking problems that came with it, this recession has not shown up yet.

It appears that the U.S. and Canadian economies have some tendency for concurrent recession although it is not certain that a recession in one country will inevitably lead to or coincide with a recession in the other.

There may be regionally disparate impacts from a recession if one does occur, but it is not at all clear that regional impacts in times of slowdown or downturn are more disparate than they are in average years of high growth overall.

**ENDNOTES**


**MENTAL HEALTH PLANNING AND POLICY**

Transforming mental health policy in Canada

**BY JOHN CONWAY, CLAUDE ROCAN, PATRICIA J. MARTENS, JOSEPH KLUGER, AND DAVE HEDLUND**

The five articles in this section on mental health policy in Canada were presented during the special roundtable discussion on “Mental Health Planning and Policy” at the 2008 World Psychiatric Association (Epidemiology and Public Health Section) Conference, which was held in Saskatoon, SK, May 12, 2008.

**Transformative Change in Mental Health:**

What can we learn from our past in Saskatchewan?

**BY JOHN CONWAY, EMERITUS PROFESSOR OF PSYCHOLOGY, UNIVERSITY OF SASKATCHEWAN**

Mental health is not a priority for our governments today. It must be made a priority, however, in order to eliminate the stigma attached to mental illness, make evidence-based therapies accessible in primary health care, integrate fragmented services across sectors, and ensure adequate funding for mental health services.

Large-scale, system-wide reform in mental health policy and programming is, in fact, a part of Saskatchewan’s history. Moreover, according to David Healy, policy and programming in mental health was transformed in the 1950s and 1960s, making Saskatchewan “one of the focal points of the psychiatric universe.”1 So, what were the highlights of these transformative changes, when government led the way, leadership was exceptional, and the work environment was ideal?2

In 1944, the CCF government led by Tommy Douglas took office with a mandate to introduce universal, publicly funded health care insurance. Within three months, the cost for hospital care for those suffering from mental illness and addictions was covered by the province.

At the same time, the government took steps to address the atrocious condition and severe overcrowding – with their 4,269 patients – of the province’s two mental institutions in Weyburn and North Battleford. By 1955, per capita expenditures on mental patients in Saskatchewan were the highest in Canada. From 1963 until 1966, care for the mentally ill was transformed by deinstitutionalization. A 72% reduction in the patient population at the Weyburn Hospital over three years time, from 1,519 to 421 patients, was the highest rate of deinstitutionalization anywhere in the world.

Most of the patients discharged were placed in small approved homes located across the province. By that time, community care for the mentally ill was better established in Saskatchewan than it was almost anywhere in North America: outpatient clinics, traveling clinics, and psychiatric wards in general hospitals – the first of their kind in North America – had been operating since 1951; and psychiatric nurses, who assumed overall responsibility for patients living in approved homes, had been trained in Saskatchewan for more than a decade.

The first fully funded provincial psychiatric research program in the country began in 1950. Innovative research programs prospered: Hoffer and Osmond’s adrenochrome theory of the biological basis of schizophrenia and their research using LSD was groundbreaking; Sommer documented the iatrogenic ill-effects of large mental institutions and designed a small psychiatric ward as a healthier place for the acutely mentally ill; Ayllon designed and researched the first-ever token economy, a social behaviour modification treatment; and McKerracher demonstrated that almost all care of the mentally ill could take place during relatively brief stays in psychiatric wards in general hospitals, or even as part of a general medical practice.

Saskatchewan psychiatric practice in the 1950s and 60s was truly “leading edge,” with other jurisdictions across North America adopting Saskatchewan’s policies and practices.

Mental health became a priority in Saskatchewan beginning in 1943 because of a few critical conditions. In simple terms, these were the essential conditions:

1) The government championed the way. Premier Tommy Douglas and the CCF were passionately committed to health care reform and mental health care was included in the transformative agenda to reform health care.
2) The leadership was exceptional. Douglas himself, who was both Premier and Minister of Public Health, was the overall architect of mental health reform. Griff McKerracher, who led the early reforms, had great confidence and faith in his vision for community psychiatry. Others quickly embraced his vision.

3) The work environment was ideal. The CCF cabinet and its senior bureaucrats provided a unique working environment in which many professionals enjoyed considerable freedom of action. Mental health professionals who came to Saskatchewan did so because they were committed to the ideals of community care. They established innovative programs which in turn attracted talented professionals to work in the province.

This is a fascinating history, to be sure, but what about today? Sadly, there is nothing left of the innovation, vigour, and excellence that characterized mental health care here in the 1950s and 60s.

In most respects, the state of mental health services in the province today is not much different than elsewhere, that is, it is in a state of utter neglect. Mental health is not a priority; in fact, it is not on the radar screen at all in most jurisdictions.

Those with mental disorders, some 20% of our citizens, are invisible, forgotten constituents.

“Forgotten constituents” was the subtitle of a 1983 report on mental health care by the Saskatchewan branch of the Canadian Mental Health Association (CMHA); it is as apt a description of those suffering from mental illness and addictions today as it was in 1983.

 Constituents and citizens played perhaps the most critical role of all in the mental health reforms of the 1950s. It is no accident that the CMHA set up its first provincial branch in Saskatchewan in 1949, with the branch acting as a leading advocate for those suffering from mental illness.

At the height of its influence in the late 1950s, CMHA Saskatchewan had 15 branches and a membership of 50,000. Imagine, if you can, 5% of our citizens advocating for mental health. The leading figures then were energetic, articulate and committed. Among its members were Douglas, his entire cabinet and all of the senior bureaucrats in mental health.

While more research, improved practices and programs, and better policies are necessary, they will not be sufficient to achieve the kind of transformative changes that we desire and had in Saskatchewan 50 years ago. The transformation of mental health care will not be achieved without citizen advocacy similar to what we had in Saskatchewan in the 1950s.

ENDNOTES


With this challenge in mind, I want to offer an enhanced perspective of mental health – one which places it firmly within the Public Health Agency of Canada’s social determinants of health approach. This framework posits health prevention and promotion as the most effective means of addressing the multiplicity of physical and mental health challenges facing Canadians.

By expanding their focus beyond traditional diagnosis and treatment of mental illness, researchers can examine these broad social health determinants more closely. By doing so, epidemiologists can play a more direct and beneficial role in planning and policy processes aimed at protecting and promoting positive mental health among Canadians.

Today, our increased knowledge of social health determinants tells us that mental health is every bit as important as physical health in helping us to support healthy families, productive workplaces, and nurturing communities.

The Agency’s population health investments are built on decades of research and policy linked to the idea that health promotion can lead to significant improvements in population health, and substantial financial savings for society, by emphasizing prevention rather than treatment. In Canada, a key milestone in health promotion was the 1974 Lalonde report, “A New Perspective on the Health of Canadians”, which brought attention to factors contributing to health and the role that governments should play.

This process continued with the 1986 “Ottawa Charter for Health Promotion”, which shifted attention beyond the health care system to broad social determinants of health such as income, employment, social status, education, and living environment. One of the Ottawa Charter’s key contributions is its emphasis on tackling health inequalities among Canadians. The Charter states explicitly that health promotion must aim to reduce differences in health status among different populations and ensure equal opportunities and resources to enable all Canadians to achieve their fullest health potential.

This emphasis on equality and social justice is also found in the Government of Canada’s 1988 report “Mental Health for Canadians: Striking a Balance”. This milestone document espoused a dual-continuum of mental health and mental disorder that supported the now empirically validated position that mental health is much more than the absence of mental illness. This innovative approach made Mental Health for Canadians the foundational document for mental health promotion in Canada.

In the two decades since the publication of the Ottawa Charter and Mental Health for Canadians, the health promotion model has enabled us to significantly improve physical health outcomes and address major health disparities. However, its application in the area of mental health has been comparatively limited because of an almost exclusive emphasis on mental illness and the failure to recognize the value of the many independent benefits of positive mental health.

Today, our increased knowledge of social health determinants tells us that mental health is every bit as important as physical health in helping us to support healthy families, productive workplaces, and nurturing communities. With this knowledge in mind, our health promotion framework focuses on achieving greater understanding of positive factors that protect and promote mental health on a daily basis: factors that help people to cope, connect, and enjoy life. This expansive approach identifies mental health as a “positive sense of emotional and spiritual well-being” that recognizes the significance of multiple factors including equity, social justice, interconnections, and personal dignity that contribute to overall mental health.

This expansive approach is driving the Public Health Agency of Canada’s efforts to “mainstream” mental health and break down traditional barriers between mental health and other key health and social factors. This mainstreaming is supported by our 2007-2012 Strategic Plan, which states the Agency’s intention to augment its capacity to address mental health and mental illness and develop a policy framework and action plan focussed on developing information and knowledge, providing effective public health advice concerning effective interventions, and liaising with the new Canadian Mental Health Commission.

In both policy development and program interventions, our focus is on horizontal collaboration and participation among institutional actors in different societal sectors. This collaborative intersectoral approach is essential to addressing mental health inequities, building resilience, minimizing risk factors, and promoting efforts to help people recover from mental illness and enjoy better mental health.

In order to achieve these complex mental health objectives, the Public Health Agency of Canada is playing a leadership role expanding our work in policy, planning, and research to include a broader, health promotion-inspired focus on multiple sectors and multiple social determinants of health.
This enhanced collaboration among research, policy, and planning professionals offers us the best hope for success in protecting and promoting positive mental health and achieving better mental health outcomes for our fellow Canadians.

“First, do no harm”:
Evaluating mental health ‘action’ plans and policies with population-based data

BY PATRICIA J. MARTENS, DIRECTOR, MANITOBA CENTRE ON HEALTH POLICY, AND CIHR/PHAC APPLIED PUBLIC HEALTH CHAIR, DEPARTMENT OF COMMUNITY HEALTH SCIENCES, FACULTY OF MEDICINE, UNIVERSITY OF MANITOBA

People living with mental illness say there’s enough research – it’s time for action! There has been action, with the new Mental Health Commission of Canada, and research on individual treatments or therapeutics. But is there “enough research” to measure gaps in care, document inequities, or evaluate health care and social policies and programs for those living with mental illness?

Epidemiologic data are critical to an evidence-informed national mental health approach. Population-based data, such as those from administrative health and social policy programs (like universal health care), give a powerful picture of rates, trends, gaps, program and policy successes, and yes, failures. The Population Health Research Data Repository housed at the Manitoba Centre for Health Policy (MCHP), University of Manitoba, contains anonymized yet person-level administrative databases including: use of physicians, hospitals, pharmaceuticals, home care, and nursing homes; vital statistics and demographics; and use of social assistance and educational outcomes.1

“First, do no harm” is a time-honoured medical tradition. So action for the sake of action can literally do harm if there is no evidence to support efficacy and effectiveness in real-world settings. There are many “measures” of what works – my lens is numeric.

Although quantitative studies are not the whole picture, they are critical players around the decision-making table. Are there enough population-based quantitative databases in Canada to enable us to “first, do no harm”, and hopefully “next, do what helps”?

Kirby’s “Out of the Shadows” report highlighted stigmatization of mental illness, and a Mental Health Commission consultation of stakeholders found that “real” stories of people leading meaningful lives while living with mental illness will help assist in changing the ways Canadians view mental illness. So we require two things: first, prevalence estimates of mental illness, and second, ways to measure program success. A Manitoba study found that 24% over five years – or one in four – had one or more of the following: depression, substance abuse, anxiety disorder, personality disorder, or schizophrenia; and 13% had additional mental illnesses, like dementia.2 This is a huge problem, yet it receives minimal attention compared to diabetes or cancer. Personal experience, along with quantitative evidence, produces powerful “evidence-based storytelling.”

Population-based quantitative data can provide understanding of prevalence, gaps, and program outcomes. Manitobans living with mental illness access primary care physicians at twice the rate of the population: 9 vs. 4 visits/year for females; and 7 vs. 3 visits/year for males. But only one or two are for mental illness; the rest are physical illnesses, often at twice the rate. Is primary health care training adequate to the task of recognizing and treating physical and mental illness co-morbidities?

Then there’s specialist access: on average, 100 Manitobans with mental illness made 100 visits to psychiatrists if they lived in the richest urban areas compared to 70 in the poorest urban areas, 30 in the richest rural areas, and only 10 in the poorest rural areas. Manitobans made 80 visits if they’re middle-aged, and only 15 if they’re elderly. So who sees psychiatrists? Urban, rich, middle-agers. Good data are critical – first to point out gaps, and then to start measuring decreases in gaps through programs such as tele-mental health.

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But is health care access the biggest challenge? Canadians living with mental illness identify housing as a huge issue, from homelessness to housing shortages, inadequate or unsafe housing, and inadequate supports in institutionalized housing. There are different options required for different age groups and situations. Manitoba data show that people living with mental illness use the universally publicly funded home care program at three to five times the rate of the general public, and 87% of residents in nursing homes have a mental illness diagnosis. Yet these services were not originally designed to meet mental illness needs, and few have mental health care providers on staff. Partly because of this study, Manitoba Health and Healthy Living announced in November 2007 an increase in psychiatric nursing staff within nursing homes, and staff education on dementia. This is reminiscent of the children’s classic A House is a House for Me by Mary Ann Hoberman, where “a web is a house for a spider, a bird builds its nest in a tree, there is nothing so snug as a bug in a rug, and a house is a house for me!” Data are critical to measure effects of various “houses” for various people: home care, nursing homes, public housing, government rental subsidies, and programs for the homeless. In Manitoba, we are working on obtaining de-identified public housing data for the Repository, a powerful way of measuring policy and program effectiveness.

The critical importance of housing is well-known. The “Housing First” model began in New York, which required first, putting a suitable roof over someone’s head and then addressing their other issues. “A house is a house for me” means that what is a good roof for one may not be for another: choice and appropriateness are essential. “Out of the Shadows” discusses the importance of housing, including a ‘Mental Health Housing Initiative’ to provide funds for building affordable housing units, rent supplement programs, and suitable home care supports and affordable housing units for seniors living with mental illness.

A Winnipeg Free Press article by Baker (April 26, 2008) headlined “Luck Not Enough” describes a good news, or “lucky” situation where a person living with mental illness experienced successful treatment integration amongst police, ambulance, emergency department, psychiatrist, and hospital services. The writer states, “I wish that our health-care system would stop depending on luck.” She then discusses the desperate need for “stable secure housing that is clean and free from bugs.” Housing is a “health” issue for those living with mental illness.

In conclusion, quantitative population-based research is critical in understanding prevalence, analyzing gaps, and measuring program and policy effectiveness. People living with mental illness, researchers, and decision-makers need the ability to measure “what works” in health care and housing options. Luck is definitely not enough, either in life or research.

ENDNOTES

The Most Important Policy and Program Objectives for Mental Health Planners in Saskatchewan: From a provincial perspective

BY JOSEPH KLUGER, COMMUNITY CARE BRANCH, SASKATCHEWAN MINISTRY OF HEALTH

In Saskatchewan, formal mental health services are delivered primarily through health regions which work closely with the Ministry of Health that provides funding, consultation, policy direction, and monitoring. There are 13 health regions in the province with a population of just over one million people. These mental health services are delivered across a continuum of care involving 100 full- and part-time rural, urban, and remote community clinics, eight in-patient mental health services, and one psychiatric rehabilitation hospital. Specialized forensic services are delivered through mental health services in the larger urban centres. The health regions focus on four major areas programmatically: Child and Youth Mental Health Services, Adult Community Services, Psychiatric Rehabilitation Services (for the severely chronically mentally ill), and In-Patient Mental Health Services. Beginning several years ago, efforts have been made within and across program areas to coordinate and integrate mental health and addictions services that traditionally have been separate. Complex cases have been identified as an emerging issue in all the major program areas.

Typically, the formal mental health system has focused on clinical services for mentally disordered people or those with significant mental health challenges, and not on the broad determinants of health and well-being. Although clinicians often take these determinants into account when providing clinical services on a case-by-case basis, the mental health sector as a whole has not done much work systemically with other sectors like public health, social, education and skills training, and employment services to address collectively the broader determinants of health and well-being.

The challenge for mental health planners in Saskatchewan is to build a provincial system of accessible, coordinated, and effective services and supports delivered primarily through regional health authorities to address the mental health needs of the residents of Saskatchewan. The system should provide a range of services including prevention and education, intervention, treatment, rehabilitation, consultation, and training. It should also measure client and system outcomes to assist in ongoing system improvements to, in turn, improve client outcomes.

Over the next five to ten years, the priority will be improving the formal mental health system in Saskatchewan to be more accessible, coordinated, and effective in delivering services to people with mental disorders or significant mental health challenges.

To illustrate using one major program area, Child and Youth Mental Health Services, improving the system means continuing to build on a plan that began two and a half years ago, following extensive stakeholder consultations (mainly through focus groups) with a range of health professionals and other sectors including social services, education, corrections, justice, early childhood services, youth, parents of affected child and youth, as well as Aboriginal communities and tribal councils. The aim of the plan is to address the concerns of the Children’s Advocate in

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Saskatchewan about access, quality, and quantity of community-based mental health services to children and youth by developing a policy framework and by improving the capacity of the existing child and youth mental health services through enhancing and/or expanding existing services. A public document outlining this plan, A Better Future for Youth: Saskatchewan’s Plan for Children & Youth Mental Health Services, is available at www.health.gov.sk.ca.

The policy framework includes the rationale for enhancing and/or expanding these services, a vision statement and beliefs, as well key initiatives and directions. The policy objectives to strengthen the capacity of the child and youth mental health services are:

- to increase the competency of professionals and
paraprofessionals to deliver evidence-based and knowledge-based mental health and wellness services for children, youth, and their families through skills training;
* to increase mental health specialist distance consultation from the three large urban centres to rural and remote regions of the province;
* to increase flexibly delivered outreach and respite services in the home, school, and community;
* to increase availability of evidence-based and knowledge-based programs across levels of impairment, need and ages; and,
* to measure client and service system outcomes to improve the system and thereby improve outcomes.

The priority initiatives identified for the recent enhancement and/or expansion of existing services are:

* mental health specialist (child psychiatry, psychology, and social work) distance consultation services;
* outreach and respite services;
* family-based residential services for youth with mental disorders who cannot live at home;
* early psychosis intervention for young people at first onset of psychosis;
* early intervention with K and grade 1 children with persistent and severe aggressive and violent behaviours;
* early preventive intervention with families with children birth to age 5 living in disadvantaged conditions;
* competency training for professionals and paraprofessionals; and,
* monitoring and evaluation of client and system outcomes.

The plan was approved and is supported by an additional investment of $3 million from the Saskatchewan Ministry of Health, bringing its contribution to community-based child and youth mental health services to an estimated $15 million annually.

To date most of the plan has been implemented and efforts will be made to address additional identified gaps in the plan over the next five to ten years. These gaps include:

* intensive community-based interventions and treatments shown to make a difference (e.g., Multisystemic Therapy for conduct disordered youth; Triple P for effective parent training; and FRIENDS Program for anxiety and depression in children) and that have the added potential of reducing reliance on other services such as in-patient mental health treatment, incarceration, physician and drug services;
* more and greater range of residential services for children and youth with mental disorders who cannot live at home; and,
* services for complex cases.

Currently there is limited data and information on the mental health and well-being of children and youth in Saskatchewan as well as the mental health and addictions services some of them received. There are two national surveys – the National Longitudinal Survey of Children and Youth and the Canadian Community Health Survey – that capture some community-based information on Saskatchewan children and youth. In addition, the Saskatchewan Ministry of Health gathers data on clients and the mental health and addictions services they received from the regional health authorities. These data include client demographics, services, or programs provided but not outcomes of services.

From these data, the Community Care Branch of the Saskatchewan Ministry of Health produces an annual report called the “Regional Health Authority Community Program Profile”. This report uses the Canadian Institute for Health Information’s Health Indicators Framework that includes eight dimensions of health system performance (acceptability, accessibility, appropriateness, competence, continuity, effectiveness, efficiency, and safety). This report is used to rationalize the distribution of limited resources across health regions. In addition, the Ministry is preparing to implement across participating health regions two client and system outcomes measures (ASIST Program and Child, and Adolescent Functional Assessment Scale) that meet the criteria of feasibility, actionability, and meaningfulness. The gathering and analysis of the information will be done at regional and provincial levels to improve the services in terms of efficiency and effectiveness.

It would be helpful for mental health planners to have information on the nature and needs of the child and youth clients with mental disorders or significant mental health challenges, including complex cases, that are in common across mental health and non-formal mental health sectors (e.g., primary health care, social services, corrections, education, early childhood, and cognitive disabilities services).
Mental Health and What We Should Do as Planners

BY DAVE HEDLUND, EXECUTIVE DIRECTOR, MENTAL HEALTH AND ADDICTION SERVICES, REGINA-QU’APPELLE HEALTH REGION

On April 5 the front page headline of the Vancouver Sun was a photo of a green garbage container with the painted caption: “What makes a Civil Society?” In all our roles and professions, we are part of the work of defining a society whose citizens thrive and answering the related questions of how we achieve it. Mental health, mental illness, and the factors which determine the status of both have to be included in any consideration of what makes a healthy, well-functioning community, province, or country.

There are two broad levels of responsibility which should be emphasized in mental health planning at the regional level. The first is the range of activities prescribed by legislated mandate, including intervention with individuals involving mental health and related professionals, planning and evaluation of new programs, refinement of existing assessment and treatment services, management of the human resource supply, and training and skill development in mental health and addiction programs.

The second level involves the effort to understand and improve the conditions which determine mental health status in communities. Working at mandated service issues only is not enough. Since these same factors also determine the outcomes that other sectors seek, we need to work with our partners to influence, positively, the determinants of mental health status and other aspects of life quality.

The first level of responsibility is written into our job descriptions; unfortunately, the second is not. The work on this second level is complex and time consuming, but it needs to occur if we are to make significant progress in improving mental health.

The pain and suffering of individuals and families with addictions and mental health conditions is profound. Some do not ask for help, but those who do cannot always get access to needed services. We should try to narrow the gap between the help that people need and the help they get. Second, there is a profound social cost to a community when the contribution of a large segment of its citizenry is compromised by addictions or other mental health conditions. There is much evidence to show how the capacity and contribution of individuals and families who are coping with mental illness or addiction is reduced. Third, mental health conditions and addictions produce a large economic burden through the increased use of costly health care services, private and public insurance claims, absenteeism from work, unemployment, and crime rates.

The barriers that block progress on improving the state of mental health policy and planning are many. First, the shame associated with mental illness and addiction persists. Over time, this shame has made it more difficult to plan responses. Second, socio-economic factors which have causal impact on mental health and all other aspects of health status are not broadly understood, or accepted, as a high priority in Canada at this time. In fact, supports in some of these areas, compared to other countries, have eroded significantly over the past two decades. Third, a narrow focus on the individual as the unit of analysis is more common than a holistic approach to assessing need and planning priorities. The public debate seems focused on the lack of access to individual medical services while there is little said about the presence or absence of the factors which determine health. Fourth, as products of our organizations, we are confident about the strengths and shortcomings of our own mandated areas, but we rarely think through or speak clearly about the

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domains of others. As a result we have little in the way of a common analysis and no joint plan that we can call on our governments and funders to support. Finally, in many areas, we are not good at collaborating, even though many of our challenges, such as addictions, crime, and homelessness, cannot be effectively dealt with in isolation by individual agencies.

There are promising developments. For example, in some cities where large numbers of people with multiple challenges, including mental illness and addiction, are without a place to live, dramatic improvements occur when the right agencies join forces and collectively develop planning efforts that involve human service agencies, partners with policy and program expertise, and representatives from community, municipal, provincial and national levels.

Fortunately, none of the barriers are insurmountable, and all have been overcome many times in many areas. There is a momentum building which should serve us well when planning in the mental health and addictions fields in the future. An important part of “what makes our society civil” will be how well we form and implement our plans in these areas in the years ahead.

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