Strengthening Federal, Provincial and Territorial collaboration on mental health and substance use health services

Taking stock of progress to-date and exploring future directions

Brief to the Canadian Psychological Association

Santis Health

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SANTIS

Insight | Expertise | Influence

About the CPA

The Canadian Psychological Association (CPA) is the national voice for the science, practice and education of psychology in the service of the health and welfare of Canadians. With more than 7,000 members, the CPA is Canada's largest association for psychology and represents psychologists in public and private practice, university educators and researchers, as well as students.

Psychologists are the country's largest group of regulated and specialized mental health providers, making our profession a key resource for the mental health treatment Canadians need.

Vision

A society where understanding of diverse human needs, behaviours and aspirations drive legislation, polices and programs for individuals, organizations and communities.

Mission

Advancing research, knowledge and the application of psychology in the service of society through advocacy, support and collaboration.

For more information please visit our website at: www.cpa.ca.

About Santis Health

Santis Health is an integrated communications, government relations and strategy firm exclusively focused on providing first-class counsel and support for clients in the health and life sciences sectors. We operate from an understanding of the context within which our clients work – including expert knowledge of the decision-making processes at play in government and across the health system, the actors and factors that weigh on those processes, and the best possible way to drive collaboration and impact.

The Santis team includes 30 full-time employees, as well as several Associates who are subject matter experts and strategic collaborators. With offices in Toronto, Ottawa and Vancouver, Santis' work blends an immersive insight of the health policy landscape with a broad network of provincial and national partners, advisors and clients. We ultimately support clients working in the sector and we support the sector in the critical work it does.

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Executive Summary

In 2017, as part of the Common Statement of Principles on Shared Health Priorities, federal, provincial and territorial governments[1] committed to work together to improve access to mental health and addiction services (also known as substance use health services), as well as home and community care.

To support this work, the federal government invested $11 billion over 10 years in targeted funding ($6 billion for home and community care, and $5 billion for mental health and addiction services), allocated to the provinces and territories on an equal-per-capita basis. The federal government negotiated a series of bilateral agreements with the provinces and territories spelling out details on how each jurisdiction planned to use the federal investment. The Common Statement of Principles also included a commitment by all participating jurisdictions to work with the Canadian Institute for Health Information (CIHI) to develop and report on a suite of common indicators.

In the context of reaching the half-way mark of the 10-year commitment, the Canadian Psychological Association (CPA) asked Santis Health to conduct a series of interviews with key mental health and substance use health services stakeholders with a view to supporting advocacy for strengthened Federal-Provincial-Territorial (FPT) collaboration and building momentum for sustained federal investment in this area.

Input and feedback was sought on: (1) the effectiveness of the federal government's targeted funding approach and accountability measures, (2) the impact and results stemming from the federal investment in terms of new initiatives and improved services, and (3) improvements to the availability and timeliness of mental health and substance use health services data to drive improvement in this sector.

Based on the input received from these interviews, Santis Health has identified ten recommendations for the CPA, and the broader mental health and substance use health community, to consider in its advocacy and outreach on mental health and substance use health services.

Recommendation 1: The federal government should accelerate the implementation of the Canada Mental Health Transfer (CMHT) and significantly increase its investment in mental health and substance use health services.

Recommendation 2: The federal government should introduce legislation to provide parity in access to mental health and substance use health services with physical health services, and to ensure that access to these services is inclusive and equity-focused. The federal government should also apply an equity lens to the renewal of the bilateral agreements.

[1] Quebec was not a signatory to the Common Statement of Principles. However, the federal government and the government of Quebec negotiated an asymmetrical bilateral agreement to enable Quebec to receive its share of the federal 10-year financial commitment.

Recommendation 3: As part of the next round of bilateral health agreements and the creation of the Canada Mental Health Transfer (CMHT), the federal government should require all jurisdictions to delineate federal and provincial-territorial contributions more clearly to funding initiatives on mental health and substance use health. This should be included in the funding agreements and all communications on the initiatives funded through the bilateral agreements and through the proposed CMHT.

Recommendation 4: The federal government should make publicly available the provincial and territorial reports to Health Canada on the use of federal funding. The federal government should also provide an annual public report on the progress achieved on mental health and substance use health services through the bilateral health agreements and the proposed CMHT.

Recommendation 5: The federal government should collaborate with the Mental Health Commission of Canada (MHCC), the Canadian Centre on Substance Use and Addiction (CCSA), the Canadian Institute for Health Information (CIHI) and the Canadian Institutes of Health Research (CIHR), and stakeholders to create a pan-Canadian national learning network to share leading practices and lessons learned in improving access to mental health and substance use health services.

Recommendation 6: The federal government work with provinces and territories, the Mental Health Commission of Canada (MHCC), the Canadian Centre on Substance Use and Addiction (CCSA), the Canadian Institute for Health Information (CIHI), the Canadian Institutes of Health Research (CIHR) and key system stakeholders to set national goals to govern the renewal of bilateral mental health and substance use health agreements, and guide the implementation of the Canada Mental Health Transfer (CMHT).

Recommendation 7: In the context of renewing bilateral health agreements and implementing the Canada Mental Health Transfer (CMHT), the federal government should set aside a portion of the funding to support the scaling up of evidence-based programs and services administered through health grants with stronger accountability for results.

Recommendation 8: The federal government should provide additional resources to the Canadian Institute for Health Information (CIHI) to work with the provinces and territories to accelerate efforts to track and report on common indicators.

Recommendation 9: The Canadian Institute for Health Information (CIHI) should work with stakeholders to ensure data on mental health and substance use health is more visible and accessible. CIHI should also accelerate its work to include public and private spending on mental health and substance use health services as part of its National Health Expenditures data series.

Recommendation 10: Governments should work with the Canadian Institute for Health Information (CIHI) and stakeholders to expand the array of common indicators, moving beyond metrics of access to a more comprehensive data set that addresses social care, perceptions of mental health status, and the determinants of health.

Background

In 2017, Federal, Provincial and Territorial (FPT) governments (with the exception of Quebec) reached agreement on a *Common Statement of Principles on Shared Health Priorities* outlining how governments would invest $11 billion over 10 years in targeted federal investments for home and community care ($6 billion) and for mental health and addiction services ($5 billion, also known as substance use health services). Specific priority areas identified for increased investment in mental health and substance use included:

- Expanding access to community-based mental health and addiction services for children and youth (age 10-25), recognizing the effectiveness of early interventions to treat mild to moderate mental health disorders;
- Spreading evidence-based models of community mental health care and culturally-appropriate interventions that are integrated with primary health services; and
- Expanding availability of integrated community-based mental health and addiction services for people with complex health needs.

Each Province and Territory (PT) signed a bilateral agreement with the federal government specifying details on how they were going to use the new federal dollars, in keeping with the priorities set out in the *Common Statement of Principles* (see Annex 1 for an overview of initiatives and investments in provinces and territories relating to mental health and substance use health funded through the bilateral agreements).

Agreements and detailed provincial-territorial action plans were posted on Health Canada's website to ensure transparency. Although the level of detail provided varies by jurisdiction, the action plans, with the exception of Quebec, identify specific initiatives to be funded from the federal investment and set out performance measures. In order to receive its annual allocation, each province and territory must attest annually that federal funding was spent in accordance with its action plan. This is done by virtue of a letter from the responsible provincial-territorial official to federal officials.

The Canadian Psychological Association (CPA) undertook a detailed analysis of the bilateral agreements and PT action plans. It found that a significant focus across the action plans was placed on integrated service delivery for children and youth, with 10 jurisdictions choosing to invest federal funding in this area. Community-based services and supports was also a significant area of focus, with eight jurisdictions reporting investments in this area. In contrast, access to addictions services, access for students, prevention and early intervention, timely access to coordinated care received little attention. E-mental health, peer support programs, and access to culturally-safe and trauma-informed mental health and addictions services for indigenous communities received modest attention.

The *Common Statement of Principles* also included a commitment by all participating jurisdictions to work with the Canadian Institute for Health Information (CIHI) to develop and report on a suite of common indicators. In 2018, FPT Ministers of Health endorsed a set of 12 common indicators, 6 for home and community care, and 6 for mental health and addictions. The 6 indicators for mental health and addictions are:

- Navigation of mental health and substance use services (released in 2022)
- Early intervention for mental health problems and substance use among children and youth (released in 2022)
- Wait times for community mental health counselling (released in 2021)
- Self-harm, including suicide (released in 2020)
- Hospital stays for harm caused by substance use (released in 2019)
- Frequent emergency room visits for help with mental health and substance use (released in 2019)

Over the past four years, CIHI has gradually rolled out the Shared Health Priorities indicators, with a tranche of 3 indicators released each year. The December 2022 report marks the first time that data on all 12 common indicators has been released.

Evolving context

Intergovernmental environment

The federal-provincial-territorial intergovernmental environment surrounding the 2017 federal investments in home care and mental health was challenging. At the time, the formula governing the Canada Health Transfer (CHT) was set to change from a guaranteed 6% annual increase (which had been in place since the 2004 FPT Health Accord "A 10-Year Plan to Strengthen Health Care") to a rolling three-year average of increases in nominal GDP, with a guarantee that annual increases would be not go below 3%.

Provinces and territories were seeking a federal commitment to set the CHT escalator at 5.2% based on a study they had commissioned by the Conference Board of Canada on the expected future growth in health spending. The federal government argued that provincial-territorial health spending had been increasing at rates of 3-4% annually, well below the 5.2% escalator they were asking for, and wanted to ensure that any new federal investments would be targeted to home and community care and mental health and addiction services, and spent as intended.

Once it became clear that the federal government was not going to change its position, the provinces and territories started to break rank and reluctantly agreed to accept the federal offer to provide $11 billion over 10 years for home and community care, and mental health and addiction services. This cleared the way for the *Common Statement of Principles on Shared Health Priorities* endorsed by Health Ministers in August 2017, followed by negotiation of a series of bilateral agreements with each province and territory, the first of which was signed by New Brunswick in December 2017, with Manitoba being the last to come on board in March 2019.

The use of bilateral agreements to flow federal health funding to provinces and territories was new and untested in the health sector. Federal officials adapted the model that was used by Employment and Social Development Canada in the area of early learning and child care, which included a framework agreement setting out principles and pan-Canadian priorities, coupled with bilateral agreements that provided further details on how each jurisdiction would spend their share of the federal investment.

Federal funding was allocated to jurisdictions on an equal-per-capita basis. Jurisdictions would have the flexibility to allocate their share of the federal funding to any or all of the common priorities listed in the framework agreement. Accountability provisions required all provinces and territories to provide a financial attestation to Health Canada on an annual basis to confirm that funding was spent as planned, as well as participate in measuring and reporting results using the common metrics developed by CIHI.

We have now reached the halfway mark of the 10-year federal funding commitment. In 2022-23, the bilateral agreements are scheduled to be renewed for the remaining 5 years of the 10-year federal funding commitment. It bears noting that the federal-provincial-territorial intergovernmental environment surrounding the renewal of the bilateral agreements is in some respects similar, and in other respects different, as compared to the situation five years ago.

Now as then, the provinces and territories have mounted a public campaign to press the federal government to increase the Canada Health Transfer. This time around, Premiers are asking the federal government to increase its share of provincial-territorial funding from the current level of 22% to 35%, representing an increase of about $28 billion annually. However, the political affiliation of provincial governments has dramatically shifted from liberal to conservative, which has significantly changed the negotiating dynamics.

In addition, the current federal government has adopted a more ambitious health agenda, including commitments on dental care, primary care, long-term care, mental health and substance use health, and pharmacare, in contrast to their more focused agenda in 2017 to improve access to home care, and mental health and addiction services. Ensuring continued success in the implementation of bilateral health agreements will be paramount as this will likely provide the template for targeted funding initiatives in other areas.

Thus far, no jurisdiction has renewed its agreement for the remaining 5 years. On November 21, 2022, the federal government announced that it had reached agreement with Quebec to provide funding for 2022-23, effectively extending the agreement by a year. Other provinces and territories continue to negotiate with the federal government and are expected to seek funding for one year pending resolution of their demand for the federal government to provide new health funding through the Canada Health Transfer.

Impact of the pandemic

The COVID-19 pandemic has had a profound impact on the lives of Canadians, magnifying feelings of isolation and hopelessness, financial concerns, and job insecurity. This, in turn, has translated into increasing symptoms of anxiety, depression, and suicidal ideation, as well as increasing use of alcohol, cannabis, and opiates.

Access to mental health and substance health use services was significantly disrupted, particularly in the first few months of the pandemic when in-person health services were shut down or curtailed and access to virtual health care visits was just beginning. That said, the impact of the pandemic continues to have a negative impact on the mental health of Canadians.

Governments across Canada have significantly ramped up virtual mental health and substance use health supports during the pandemic, including Wellness Together Canada, a new federal online portal, and similar initiatives across several provinces and territories. It is not yet clear how the pandemic will have impacted collaborative work on mental health and addiction services across jurisdictions. It is likely that implementation of some of the initiatives funded through the bilateral agreements may have been delayed. As part of the Safe Restart Agreement, the federal government also provided a one-time of $500 million to provinces and territories to address immediate needs and gaps in the support and protection of people experiencing challenges related to mental health, substance use, or homelessness.

Spending on publicly-funded mental health and substance use health services

Understanding current levels of spending on mental health and substance use health services in Canada's health system is essential to benchmark the impact of targeted federal spending in this area. Unfortunately, CIHI does not report, in detail, on mental health and substance use health spending as part of its regular reporting on national health expenditures.

The Mental Health Commission of Canada estimates that in 2015, total public and private spending on mental health services amounted to $15.9 billion, including $3.8 billion in inpatient services, $6.5 billion in community services, $2 billion in physician services, and $3.6 billion in prescription drugs. These numbers are likely higher in 2022, but more complete updated public and private estimates are not available.

It is important to note that these figures do not include employer-based expenditures on mental health care services (e.g., psychotherapy provided by psychologists) noting that most health care is delivered by providers whose services are not covered by provincial-territorial health plans, and are either funded through employer-based extended health plans or out-of-pocket. In 2021, insurers paid our $580 million in mental health benefits, up 45% from 2020, and 75% since 2019.

Furthermore, as part of the proposed creation of the Canada Mental Health Transfer (CMHT), the federal Liberals have committed to spend an additional $4.5 billion over five years on mental health, bringing federal support for mental health services to $2.6 billion per year by 2025-26

(see Table 1). This would increase the federal share of spending on mental health and substance use health services to a total of $2 billion per year at maturity. With financial support from the federal government, work is also underway through the Standards Council of Canada to develop national standards for mental health and substance use health services.

Table 1: Federal spending commitments on mental health and substance use health services from 2017-18 to 2026-27 ($ millions)

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	2026-27	Total
Bilateral agreements	100	250	450	600	600	600	600	600	600	600	5000
Safe Restart Agreement				500	0	0	0	0	0	0	500
Canada Mental Health Transfer*					250	625	625	1000	2000	2000	6500
Total	100	250	450	1100	850	1225	1225	1600	2600	2600	12000

*Although the federal government has committed to create the CMHT, it has not committed to a specific timeline nor to spending levels. Figures in the table are sourced from the 2021 Liberal election platform, with funding for 2026-27 assumed to continue at the same level as 2025-26.

Calls to accelerate federal investments and adopt parity legislation

The Canadian Alliance on Mental Illness and Mental Health (CAMIMH), a member-driven alliance of 16 mental health organizations that represent people with lived or living experience, their families and caregivers, and health care providers, has stepped up efforts to encourage the federal government to deliver on its election promise and accelerate the implementation of the Canada Mental Health Transfer (CMHT). In an October 2022 letter to The Honourable Carolyn Bennett, Minister of Mental Health and Addictions, CAMIMH and 49 other organizations raised significant concerns about delaying the implementation of the CMHT and urged the government to include this in Budget 2023.

CAMIMH has also strongly advocated for the adoption of federal mental health and substance use health parity legislation (i.e., Mental Health and Substance Use Health Care For All Parity Act) that would ensure timely access to inclusive and accessible mental health and substance health use services in a manner similar to how universal access to physician and hospital services are enshrined in the *Canada Health Act*. More recently, the call for federal parity legislation has been supported by the Canadian Mental Health Association (i.e., a Canada Universal Mental Health and Substance Use Health Act).

CIHI Report on Pan-Canadian Mental Health and Substance Use Health Indicators

On December 8, 2022, CIHI released its fourth annual report on Shared Health Priorities indicators, reporting results on all 12 common indicators for the first time. Regrettably, not all jurisdictions are reporting yet on all indicators. That said, considerable efforts are being made by the provinces and territories to expand coverage in existing data holdings, to improve data quality, to develop common information standards and to explore new data sources for public reporting. Indicator results will be updated and refined as more and better data becomes available.

Some of the key take-aways on mental health and substance use health services include:

- In 2022, only 2 in 5 Canadians say they always or usually had support navigating mental health and/or substance use health services, ranging from 17% in Nova Scotia to 54% in New Brunswick, with lower proportions among LGBTQ populations, individuals with less education, and individuals with lower income. Three provinces and territories did not report data.

- In 2022, three in five children and youth with early needs accessed at least one community mental health and/or substance use health service in the last 6 months, ranging from 45% in Nova Scotia to 72% in New Brunswick, with more than half indicating that mental health and/or substance use health services were not easy to access. Five provinces and territories did not report data.

- In 2021, half of Canadians wait less than a month (22 days) for ongoing counselling services in the community, ranging from 4 days in the Northwest Territories to 62 days in New Brunswick. About 1 in 10 Canadians wait about 4 months, with children and youth waiting longer than adults. Of concern, five provinces and 2 territories did not provide any wait time data.

- In 2020, 23,300 Canadians were hospitalized or died by intentionally harming themselves, with 1 in 14 of those hospitalized for self-harm having had 2 or more hospital stays for self-harm in a year. Almost 30% of those hospitalized for self-harm are young women and almost 30% of those who die by suicide are middle-aged men. Rates of death by suicide vary across jurisdictions from 50 per 100,000 in Nova Scotia to 222 per 100,000 in the Northwest Territories. One territory did not report data.

- In 2021, every day, more than 500 Canadians (182,500 per year), two-thirds of which are men, are hospitalized because of harm from alcohol or drugs, more than heart attacks and strokes combined. Alcohol contributed to more than half of stays caused by substance use. Four in 10 adults and 7 in 10 children and youth hospitalized for harm caused by substance use also have a mental health condition. The rate of hospital stays

per 100,000 for harm caused by substance use varied from 399 in Nova Scotia to 1,901 in the Northwest Territories. One province did not report data.

- In 2019, nearly 1 in 10 Canadians who visit the Emergency Room (ER) for help with mental health and substance use had more than 4 visits a year. Half of those who visit the ER for help with mental health and/or substance use were under the age of 35. Thirty-four percent had a mental health condition only, 19% had a substance use condition only, and 47% had both mental health and substance use conditions. Five provinces and territories did not report data.

CIHI notes that results from the pandemic period, and trends over time, should be interpreted with caution. Over time, the common indicators will tell a clearer story about access to care across the country, helping to identify where there are gaps in services to improve care at the front lines and to better meet the needs of Canadian patients and their families.

Stakeholder views

As part of this work, the Canadian Psychological Association (CPA) asked Santis to conduct a series of key informant interviews with mental health and substance use health services stakeholders with a view to supporting advocacy for strengthened FPT collaboration and building momentum for sustained federal investment in this area.

Interviews were carried out between November 17, 2022 and January 24, 2023. A list of individuals who participated is listed in Annex 2. Input and feedback was sought on: (1) the effectiveness of the federal government's targeted funding approach and accountability measures, (2) the impact and results stemming from the federal investment in terms of new initiatives and improved services, and (3) improvements to the availability and timeliness of mental health and substance use health services data to drive improvement in this sector. A list of the questions is included in Annex 3.

Targeted funding and accountability

Targeted funding welcomed, but insufficient

Participants generally applauded the growing attention given to mental health and substance use health over the past 20 years and welcomed the targeted funding provided from the federal government through the 2017 bilateral agreements. Several noted that in the wake of the COVID-19 pandemic, interest in mental health and substance use health has grown significantly and has pushed governments to further invest in the sectors.

However, many noted that there are significant gaps in the system that need to be addressed, notably in (timely) access to services, research, and education and training of the workforce. There is a general acknowledgement that the sector is underfunded compared to the rest of the

health care system, and that public spending on mental health and substance use health as a share of total public health expenditures needs to increase from its current level of 7% to a minimum of 9% (Canadian Alliance on Mental Illness and Mental Health [CAMIMH]). More recently, the Royal Society of Canada has called on governments to increase their share of spending on mental health and substance use health services to 12% of their health budgets.

There was also concern among some participants that the majority of provincial and territorial initiatives supported by the bilateral agreements were centred around mental health services, with only a few examples of initiatives targeted to improving access to substance use health services. However, it was noted that federal funding for substance use services was also provided to provinces and territories through the $150 million Emergency Treatment Fund.

Participants also observed that current federal funding for mental health and substance use health under the bilateral health agreements is only a small fraction of what provinces and territories spend in this area and is not sufficient to drive needed changes in the long run. Viewed over the 10-year commitment, $5 billion in federal funding may appear large on its own, but on an annual basis, federal funding accounts for less than 5% of provincial-territorial governments' expenditure on mental health and substance use health services.

Some participants proposed that the federal government impose that a certain percentage of provincial-territorial budgets be spent toward mental health and substance use health services as a condition of receiving federal dollars. However, most recognized the need for the federal government to increase its investment in mental health and substance use health services in order to drive more transformative changes in this sector and called on the federal government to accelerate the implementation of the CMHT.

Recommendation 1: The federal government should accelerate the implementation of the Canada Mental Health Transfer (CMHT) and significantly increase its investment in mental health and substance use health services.

A common concern among participants is the reality that the *Canada Health Act* does not explicitly include mental health and substance use health services as insured services. Many participants proposed revisiting the *Act* or introducing new federal legislation to ensure parity in access to service across mental health, substance use health and physical health, to enshrine equity as a core principle and to strengthen the reach and impact of community programs, especially for racialized and 2SLGBTQI+ communities that were particularly affected by the pandemic.

Some participants suggested that an equity lens should be used in the renewal of the bilateral agreements. One participant called for the inclusion of deaf and disabled people within mental health frameworks across the country. ASL (American Sign Language)/LSQ (Quebec Sign Language) and Indigenous sign language are legally required in Canada, however hospitals are not providing these translation services under the pretext of lack of funding.

Recommendation 2: The federal government should introduce legislation to provide parity in access to mental health and substance use health services with physical health services, and to ensure that access to these services is inclusive and equity-focused. The federal government should also apply an equity lens to the renewal of the bilateral agreements.

Accountability has improved, but still difficult to follow the money

Participants viewed the targeting of federal dollars and the inclusion of detailed action plans in the bilateral agreements as positive steps towards improved accountability. However, many remain concerned about a lack of transparency in how the federal funding is used, particularly since it is impossible to differentiate between federal, and provincial and territorial sources of funding when government initiatives are rolled out. Several participants suggested that annual reports currently provided to Health Canada by provincial and territorial governments on the use of federal funding should be made public. This would reassure Canadians that federal funding for mental health and substance use health is protected and used as intended.

Recommendation 3: As part of the next round of bilateral health agreements and the creation of the Canada Mental Health Transfer (CMHT), the federal government should require all jurisdictions to delineate federal and provincial-territorial contributions more clearly to funding initiatives on mental health and substance use health. This should be included in the funding agreements and all communications on the initiatives funded through the bilateral agreements and through the proposed CMHT.

Recommendation 4: The federal government should make publicly available the provincial and territorial reports to Health Canada on the use of federal funding. The federal government should also provide an annual public report on the progress achieved on mental health and substance use health services through the bilateral health agreements and the proposed CMHT.

Delivering results

Creating a learning system for mental health and substance use health services

Several participants highlighted successful programs supported through the bilateral agreements that can be easily scaled up. For instance, in Ontario, there has been significant investment in Rapid Access Addictions Medicine (RAAM) clinics. As part of the growing networks of rapid access clinics for specialized services, these clinics are increasing timely access to addiction and substance use health services and are demonstrating promising health outcomes. The rollout of integrated youth mental health services hubs and stepped care approaches was also referenced by several participants as examples of how the bilateral health agreements have contributed to improving access to evidence-based services across the country.
Federal dollars have also contributed to the expansion of e-mental health services. Participants would encourage further investments in digital health and virtual care initiatives as an efficient pathway to improving access to mental health and substance use health services. Initiatives launched in PEI around Student Wellbeing Teams and the Mobile Mental Health Teams are also showing promise.

Research was identified as a key area where further investment is needed. Participants support the acceleration of integrated research development and integrated data collection across the country. This has been done in other areas and can be replicated in the mental health and substance use health sectors. At the same time, participants urged the federal government to more effectively coordinate activities across national organizations such as CIHI, the Canadian Institutes of Health Research (CIHR), the Mental Health Commission of Canada (MHCC) and the Canadian Centre for Substance Use and Addiction (CCSA).

Overall, participants strongly encouraged governments at all levels to work together with stakeholders to create and share knowledge, leading practices and lessons learned. Strong data governance, enhancing capacity for research and data analytics, expanding the array of system performance indicators are seen as essential components of a more robust learning system to drive improvement in access to mental health and substance us health services.

Recommendation 5: The federal government should collaborate with the Mental Health Commission of Canada (MHCC), the Canadian Centre on Substance Use and Addiction (CCSA), the Canadian Institute for Health Information (CIHI) and the Canadian Institutes of Health Research (CIHR), and stakeholders to create a pan-Canadian national learning network to share leading practices and lessons learned in improving access to mental health and substance use health services.

Driving system improvement through the next round of agreements

Participants acknowledged that a balance needs to be struck between the desire to drive progress in key areas at the national level and the reality that provinces and territories all have different health care systems and different approaches to organizing, managing and delivering services. They generally felt that during the initial five-year period, the bilateral health agreements achieved a good balance in identifying pan-Canadian priority areas while leaving some discretion to the provinces and territories to align their own priorities and plans to the pan-Canadian framework.

However, for the next iteration of these agreements, participants would like to see governments take a more concerted approach to setting a common agenda -- for example, increasing access to evidence-based care, reducing the number of opioid deaths, reducing homelessness, and reducing hospitalizations caused by mental health and substance use – and more effectively aligning activities across the federal, provincial and territorial governments, the MHCC, the CCSA, CIHI and the CIHR to achieve these goals.

Recommendation 6: The federal government work with provinces and territories, the Mental Health Commission of Canada (MHCC), the Canadian Centre on Substance Use and Addiction (CCSA), the Canadian Institute for Health Information (CIHI), the Canadian Institutes of Health Research (CIHR) and key system stakeholders to set national goals to govern the renewal of bilateral mental health and substance use health agreements, and guide the implementation of the Canada Mental Health Transfer (CMHT).

Participants also stressed the need to scale-up evidence-based programs and approaches that have demonstrated their effectiveness and have the greatest potential to improve mental health and substance use health outcomes. These could include:

- Integrated children and youth mental health and substance use health service hubs
- Structured psychotherapy programs
- Rapid access addiction medicine clinics
- Virtual mental health and substance use health services
- Stepped care approaches to delivering mental health and substance use health services
- Housing first approaches to reduce homelessness and its impact on mental health and substance use health

A portion of the funding to support these initiatives could be delivered through health grants similar to an approach previously used by the federal government decades ago to support change in provincial health systems (i.e., National Health Grants). Funding for these activities would not be apportioned to provinces and territories on an equal-per-capita basis as under the current federal transfer models. Instead, provinces and territories interested in adopting or scaling up these models would apply for federal funding and would be accountable to the federal government and to their residents for the successful implementation of the models.

These funds would be coupled with research and data sharing components to ensure that insights generated from these innovations is shared across jurisdictions. Grants would be announced as a collaboration between the federal government and the provincial-territorial governments, and details of the grants and their outcomes would be shared publicly.

To drive innovation in Canada, many participants refer to successful strategies from other countries that can be adapted with minor changes. For instance, the National Mental Health and Suicide Prevention Agreement signed by the Commonwealth and state governments in Australia could be easily adapted to the Canadian context.

Recommendation 7: In the context of renewing bilateral health agreements and implementing the Canada Mental Health Transfer (CMHT), the federal government should set aside a portion of the funding to support the scaling up of evidence-based programs and services administered through health grants with stronger accountability for results.

Measuring progress and driving change

Accelerating progress to get all jurisdictions publicly reporting on common indicators

Participants indicated that the development and roll-out of common indicators is a great start. Some participants indicated that jurisdictions are using the indicator on wait times for community-based mental health services to shorten the wait time for the first intervention. Some acknowledged that although the indicators do not tell the full story, they are helping to better

characterize the problems that policy-makers and system leaders are trying to address. Moving forward, a key priority is to increase the quality of data across jurisdictions. Federal funding will be helpful not only in helping provinces-territories collect better data, but also in ensuring uniformity in reporting.

Some participants were concerned that the provinces and territories are not properly evaluating programs in their jurisdiction, partly due to the lack of quality data. Participants would encourage the federal government to provide additional funding support to CIHI to work with provincial and territorial governments to accelerate the development and roll-out of common indicators and operationalizing key concepts (e.g., setting clear guidelines on measuring wait times). Participants also stressed that mental health and substance use health data needs to be disaggregated to take into consideration marginalized communities, and people with disabilities.

Participants confirmed that without standardized health system key performance indicators and benchmarks, it will be very difficult to achieve a high performing mental health and substance use health system. This does not exist in any of the provinces and territories as of yet.

Participants suggested that Ontario's Mental Health and Addictions Centre of Excellence is making progress in tackling this challenge and that CIHI could leverage this work at the national level. A few participants also proposed that the federal government should provide financial support to the provinces and territories to develop their own measurement and reporting systems in parallel to the national indicators.

Recommendation 8: The federal government should provide additional resources to the Canadian Institute for Health Information (CIHI) to work with the provinces and territories to accelerate efforts to track and report on common indicators.

Several participants suggested that reporting on common indicators for the Shared Health Priorities is not as visible and accessible as it should be. Participants also noted that future work include mental health and substance use health as a distinct category of spending in CIHI's National Health Expenditure data series needs to be accelerated to provide a clearer picture of public and private spending in this area.

A significant proportion of mental health and substance use health services are privately-funded either through employer-based extended health benefit plans, or out-of-pocket. However, data from these services are not captured by CIHI. To provide a complete picture of mental health and substance use health spending in Canada, data from the private sector needs to be accounted for.

Recommendation 9: The Canadian Institute for Health Information (CIHI) should work with stakeholders to ensure data on mental health and substance use health is more visible and accessible. CIHI should also accelerate its work to include public and private spending on mental health and substance use health services as part of its National Health Expenditures data series.

Expanding the scope of common indicators

While recognizing the constraints to expanding the scope of common indicators, several participants believe that increasing the breadth of the indicators would provide a clearer picture of the state of mental health and substance use health services in Canada. More specifically, participants suggested that tracking and reporting on indicators relating to social care, perceptions of positive change among recipients of care, and the social determinants of health is crucial.

Data collection and analysis needs to be more transparent and uniform across jurisdictions. This requires enhancing the data infrastructure behind the indicators and creating robust channels through which stakeholders share their data with governments.

Recommendation 10: Governments should work with the Canadian Institute for Health Information (CIHI) and stakeholders to expand the array of common indicators, moving beyond metrics of access to a more comprehensive data set that addresses social care, perceptions of mental health status, and the determinants of health.

Conclusion

At the mid-way point of the federal government's 10-year investment in mental health and substance use health services, there is a sense among stakeholders that positive change is underway. Mental health and substance use health is benefitting from increasing attention on the national stage and within provincial and territorial health systems, progress is being made in rolling out initiatives despite the disruption caused by the COVID-19 pandemic, and CIHI has now rolled out the complete set of 12 common indicators to benchmark progress.

Although there is optimism in the community, significant challenges remain. This includes the lack of national framework policies such as the adoption of parity legislation to place mental health and substance use health services on par with physical health services, as well as the need to implement a dedicated funding vehicle through the Canada Mental Health Transfer. In addition, stakeholders have identified a number of areas for improvement in the transparency and accountability provisions of the bilateral health agreements, in the capacity to share leading practices across jurisdictions, and in the approach to measuring and reporting progress.

Given that federal and provincial-territorial governments are likely to come to agreement on a new national health funding deal in the coming weeks, these recommendations provide an opportunity for the Canadian Psychological Association (CPA), and the broader mental health and substance use health community, to work with its partners to advocate for measures that will benefit the mental health and substance use health of all Canadians.

References

Bartram M. *Making the most of the federal investment of $5 billion for mental health.* CMAJ. 2017 Nov 6;189(44):E1360-E1363. doi: 10.1503/cmaj.170738. PMID: 29109209; PMCID: PMC5675542; https://www.cmaj.ca/content/189/44/e1360/tab-e-letters

Canadian Alliance on Mental Illness and Mental Health (CAMIMH), *From Out Of The Shadows And Into The Light…Achieving Parity In Access To Care Among Mental Health, Substance Use And Physical Health: The Case For A Mental Health And Substance Use Health Care For All Parity Act In Canada*, June 2021, https://www.camimh.ca/_files/ugd/b625ef_56eae3dfa1144ab4a985744248f673e3.pdf

Canadian Alliance on Mental Illness and Mental Health (CAMIMH), Letter to Minister Bennett calling for the creation of a Canada Mental Health Transfer, October 2022 https://www.camimh.ca/_files/ugd/b625ef_a605a3ecda004661998250b9bd5fdc1d.pdf

Canadian Institute for Health Information, *Common Challenges, Shared Priorities – Measuring Access to Home and Community Care and to Mental Health and Substance Use Services in Cana*da, Volumes 1-4, https://www.cihi.ca/en/shared-health-priorities

Canadian Life and Health Insurance Association. Canadian Life & Health Insurance Facts – 2022 Edition, http://clhia.uberflip.com/i/1478447-canadian-life-and-health-insurance-facts-2022-edition/11?

Canadian Psychological Association, Overview of Federal, Provincial-Territorial Bi-Lateral Funding Agreements For Mental Health & Addiction Services, 2017/18 – 2021/22 https://cpa.ca/docs/File/Government%20Relations/FMHA%20Overview%202017-18%20to%202021-22%20March%2030%202020.pdf

Government of Canada, A Common Statement of Principles on Shared Health Priorities, https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/principles-shared-health-priorities.html

Liberal Party of Canada, A Comprehensive Plan for Mental Health Care Across Canada, 2021, https://liberal.ca/our-platform/a-comprehensive-plan-for-mental-health-care-across-canada/

Marchildon, Greg, *Health funding: Why 12 federal-provincial deals are better than none*, Healthy Debate, https://healthydebate.ca/2017/04/topic/health-care-funding-2/

McIntosh, Tom, and Alanna DeCorby. *From National Accords to Bilateral Agreements: Transforming Canadian Health Care Intergovernmentalism*. The School off Public Policy Publications 15 (2022), https://journalhosting.ucalgary.ca/index.php/sppp/article/view/74113

Mental Health and Substance Use During COVID-19, Summary Report, Mental Health Commission of Canada and the Canadian Centre for Substance Use and Abuse, 2020, https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2021-02/mhcc_ccsa_covid_leger_poll_eng.pdf

Mental Health Commission of Canada, *Strengthening the Case for Investing in Canada's Mental Health System: Economic Considerations*, March 2017, https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2017-03/case_for_investment_eng.pdf

Royal Society of Canada, *Easing the Disruption of COVID-19: Supporting the Mental Health of the People of Canada*, October 2020, https://rsc-src.ca/sites/default/files/MH%20PB_EN_1.pdf

Shared Health Priorities and Safe Long-term Care Fund, Bilateral Agreements, https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities.html

Annex 1: Provincial and territorial mental health and substance use initiatives funded through targeted federal funding

P/T	Share of $2B MHA funding	Jurisdictional Initiatives
BC	$262M	• Strengthen Primary Care Capacity to Respond to Mental Health and Addictions, With a Focus on Prevention/Early Intervention and Children / Youth • Expand Access to Culturally Safer and Trauma Informed Mental Health and Addictions Services for Indigenous Communities • Improve Seamlessness Across Systems of Care so That People Can Ask Once and Get Help Fast • Increase Access for Students to Mental Health and Addictions Prevention and Early Intervention Services
AB	$234M	• Improve access to community-based addiction and mental health services • Mental health and addiction services for children and youth • Specialized mental health and addictions programs
SK	$63M	• Improved access to community mental health supports • Enhanced delivery of evidence based services • Improved Mental Health and Addictions Services for youth and young adults
MB	$73M	• Increasing timely access to coordinated care for mental health and addictions services for Manitobans • Implementation of peer support in formal healthcare settings (includes EDVICAP) • Implementation of pregnancy and infant loss program
ON	$773M	• Child and Youth Community-based MHA Services (e.g. early psychosis intervention, youth addictions treatment) • Community-based Core MHA Services (e.g. counselling and psychotherapy, adult addictions treatment) • Integrated community-based MHA services for people with complex needs (e.g. supportive housing, justice supports)
QC *	$456M	• Investments to support Quebec psychotherapy program, improved accommodation and community retention services to prevent psychiatric hospitalizations and reduce psychiatric ward stays, consolidation of assertive community treatment (ACT) and variable intensity support (VIS) services, enhanced access to psychologists for youth (ages 0-18), first psychotic episode services for young people aged 12 to 35, and enhanced community crisis services.
NB	$41M	• Enhanced action plan on addictions and mental health • Integrated community health care services for youth
PE	$8M	• Student well-being program • Mobile mental health crisis program
NS	$50M	• Enhanced integrated service delivery for children and youth • Enhanced access to community based MHA supports
NL	$29M	• Integrated service delivery for children, youth and emerging adults • E-mental health initiatives • Improved access to addiction services • Improved community-based services

YK	$2M	• Improving access to community-based mental wellness and substance use services • Culturally appropriate and Integrated interventions
NT	$2M	• Enhanced program delivery, professional development and support, and external supports
NU	$2M	• Enhanced supports for suicide prevention, mental health and addition interventions, and postvention

Annex 2: List of key respondents

National Health Organization/Agency/Provider Perspective
Fred Phelps – Executive Director, Canadian Association of Social Workers

Lived Experience Perspective
Ellen Cohen – National Co-ordinator of the National Network for Mental Health
Chris Summerville – Chief Executive Officer, Schizophrenia Society of Canada

Public Policy Experts
Greg Marchildon – Professor Emeritus, Institute of Health Policy, Management and Evaluation University of Toronto
Bill Tholl – Health Policy Consultant, Associate Professor at McMaster University, and Senior Policy Advisor for CHLNet

Community-Based Perspective
Steve Lurie – Past-CEO, Toronto branch of Canadian Mental Health Association, and adjunct professor, University of Toronto Faculty of Social Work
Ian Boeckh – President and Director, Graham Boeckh Foundation
Kim Corace – Vice-President, Innovation and Transformation, Royal Ottawa Hospital

Pan-Canadian Health Organizations
Michel Rodrigue – President, Mental Health Commission of Canada
Mary Bartram – Director, Policy, Mental Health Commission of Canada
Kathleen Morris – Vice-President, Research and Analysis, Canadian Institute for Health Information

Provincial-Territorial respondents
Rebecca Jesseman – Director, Planning and Operations, Health PEI

Health Canada Officials

Annex 3: Questionnaire

1. **Perspective on mental health and addiction services:**
   A) What is your perspective on the evolving role and value of expanded access to publicly funded mental health and addiction services in Canada's health care system?
   B) Do you believe that local communities in your jurisdiction are devoting sufficient public resources and attention to the provision of timely access to mental health and addiction services?

2. **Targeted funding and accountability:** In contrast to the Canada Health Transfer, whereby the federal government transfers health funding to provinces and territories with no strings attached, the bilateral agreements on Shared Health Priorities were intended as a vehicle to target multi-year federal investments to traditionally under-funded areas of the health system, and to improve accountability to Canadians.

   A) To what degree do you think that this new arrangement was successful in ensuring that federal dollars were directed as intended to mental health and addiction services?
   B) What improvements could be made to strengthen these agreements for the future?

3. **Delivering results:** As part of the bilateral health agreements, provinces and territories committed to implementing a range of initiatives in mental health and addiction services that are aligned with the priorities articulated in the Common Statement of Principles.

   A) Have you seen concrete on-the-ground improvements in the areas of mental health and addiction services across your jurisdiction pursuant to these agreements?
   B) Do you think that these initiatives would have been implemented if federal funding had not been available?

4. **Measuring progress and driving change:** As noted above, the Canadian Institute for Health Information (CIHI) has now rolled out the full suite of Shared Health Priorities indicators (12 in total of which 6 focus on mental health and addictions services). Not all jurisdictions are in a position to report on each indicator at the moment, but the plan is to gradually expand reporting across all jurisdictions.

   A) Over the past few years, have you seen improvements in your jurisdiction in the availability and timeliness of mental health and addiction services data?
   B) Do you think that more consistent measurement and data reporting within jurisdictions on mental health and addiction services will help to build momentum for sustained change?
   C) Does your organization use CIHI data on shared health priorities in its research and advocacy? If so:
      a. How do you use the data? More generally, what improvements could be made to performance measurement and reporting on mental health and addiction services?
      b. What are the current data gaps that need to be addressed to properly feed into these indicators?

5. **Other comments or feedback for consideration:**
   A) Do you have any additional comments to share on the bilateral health agreements and common metrics for mental health and addictions services?