CANADIAN ALLIANCE ON MENTAL ILLNESS AND MENTAL HEALTH

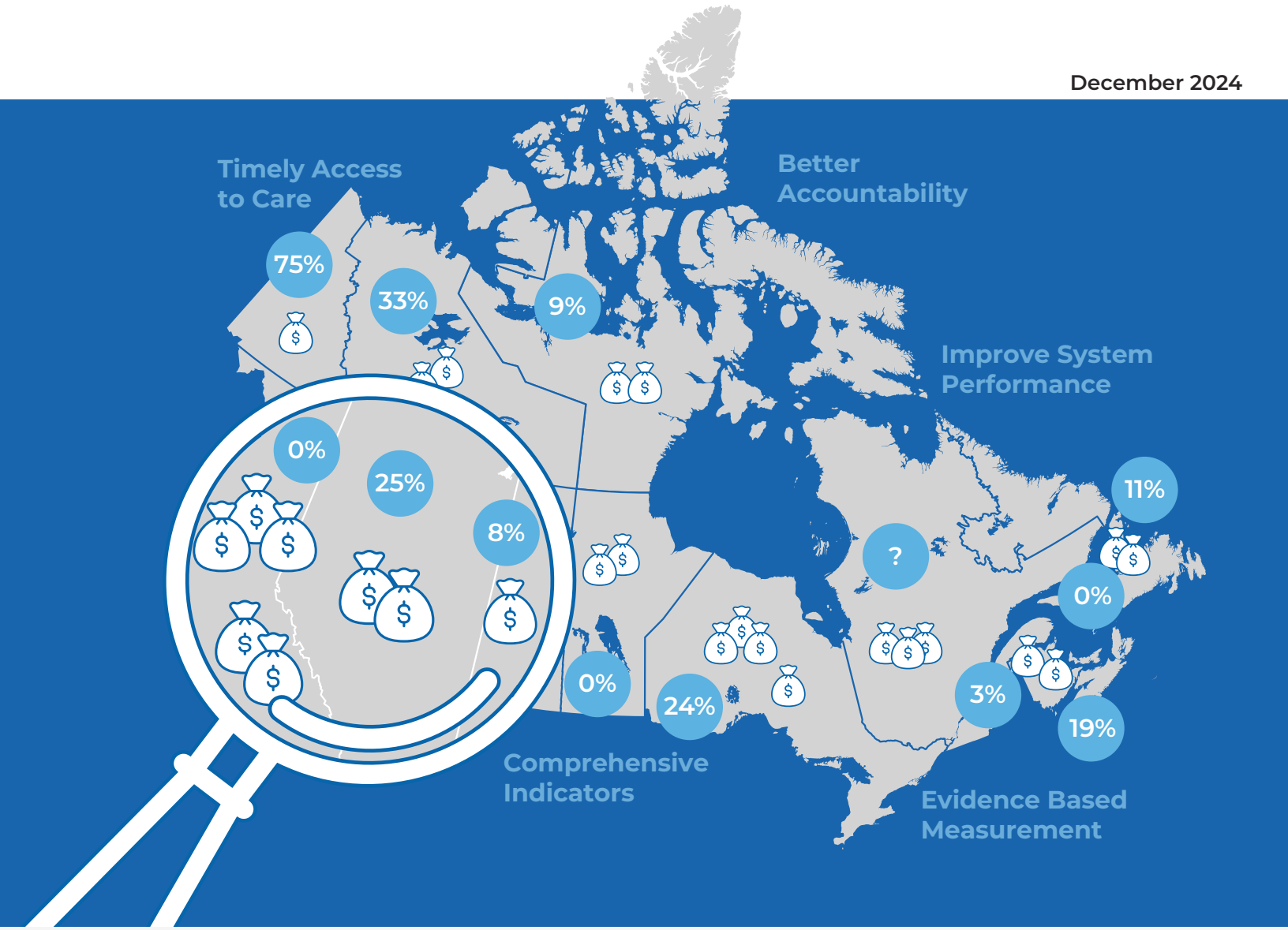
ALLIANCE CANADIENNE POUR LA MALADIE MENTALE ET LA SANTÉ MENTALE

Take the Money and Run?

How Accountable are the Provinces and Territories in Spending Federal Funding on Mental Health & Substance Use Health Care?

A Review of 2023 and 2017 Bi-Lateral Funding Agreements for Mental Health & Substance Use Health Services, 2023/24 – 2025/26

December 2024



Canadian Association for Suicide Prevention
Canadian Association of Social Workers
Canadian Consortium for Early Intervention in Psychosis
Canadian Counselling and Psychotherapy Association
Canadian Association of Occupational Therapists
Canadian Perinatal Mental Health Collaborative
Canadian Federation of Mental Health Nurses
Canadian Medical Association
Canadian Mental Health Association
Canadian Psychiatric Association
Canadian Psychological Association
College of Family Physicians of Canada
Community Addictions and Peer Support Association
Medical Psychotherapy Association of Canada
National Initiative for Eating Disorders
National Network for Mental Health
Psychosocial Rehabilitation Canada
Schizophrenia Society of Canada

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Who We Are

The Canadian Alliance on Mental Illness and Mental Health (CAMIMH) is the national voice for mental health in Canada. Established in 1998, CAMIMH is a member-driven alliance of 18 mental health and substance use health organizations representing people with lived or living experience, their families and caregivers, and health care providers. CAMIMH is focused on the leadership role of the federal government in addressing issues of mental health and substance use health.

Vision

We envision a country where all Canadians enjoy good mental health and substance use health.

Mission

Canadians with lived and living experience of mental health and substance use health problems, their families and care providers must have timely access to care, support and respect to which they are entitled and in parity with other (physical) health conditions.

For more information, please visit our website at www.CAMIMH.ca.

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Executive Summary

In 2023, the federal, provincial and territorial governments signed a series of bi-lateral agreements called ***Working Together to Improve Health Care for Canadians***. These agreements included $25 billion, over ten years, to be invested in four priority areas (of which one is mental health and substance use health care), as well as the remaining funding from the 2017 mental health and addictions services agreement ($5 billion). Knowing that these are lengthy and complex documents, the Canadian Alliance on Mental Illness and Mental Health (CAMIMH) thought it would be valuable to:

1. Clearly lay out the funding that has been committed to mental health and substance use health in both agreements
2. Identify the provincial and territorial priorities attached to this funding
3. Determine how the provinces and territories will hold themselves accountable to the public in terms of the benchmarks and targets they have selected for mental health and substance use health; and
4. Identify a path forward to improve public reporting on health system performance

Given the longstanding history of the provinces and territories demanding maximum cash from the federal government for health care with minimal strings or accountabilities, CAMIMH wanted to better understand if the provinces and territories are just taking the money and running, or are they putting their money where their mouths are when it comes to improving timely access to accessible and inclusivemental health and substance use health services? Our findings are as follows:

Funding

Over the course of the 2023/24-2025/26 timeframe, the provinces and territories will invest a total of $9.3 billion ($7.5 billion from the 2023 Working Together to Improve Health Care in Canada agreement, and $1.8 billion from the 2017 mental health and addictions agreement).

- Of the $25 billion that has been allocated to the provinces and territories beginning in 2023, they are allocating, on average, only **15.9%** for mental health and substance use health care services.
- PEI, Manitoba and British Columbia have allocated **$0 (0%)** funding to mental health and substance use health services, and seven of the 12 reporting provinces and territories are allocating **10% or less** of the available 2023 bi-lateral funding ($25 billion) to mental health and substance use health services. Median funding stands at **8.45%** with the highest proportion being the Yukon (75.1%), Northwest Territories (33.3%), Alberta (25.2%), Ontario (23.9%) and Nova Scotia (18.8%).
- Given the crisis of timely access to care for those with mental health and substance use health problems, why are so many provinces and territories investing so little new federal dollars to improve and expand access to mental health and substance use health care services?

This is very concerning given that publicly available data tells us that Canada's mental health investments account for roughly 5% of their health budgets, which is significantly below the recommended **12%** by the Royal Society of Canada, which CAMIMH supports. Clearly, there is room to grow our public (federal, provincial and territorial) investments in mental health and substance use health services.

Provincial-Territorial Common Indicators

Three common national indicators were agreed to by the federal, provincial and territorial governments: (1) median wait time for community mental health and substance use services; (2) percentage of youth aged 12 to 15 with access to integrated youth services for mental health and substance use; and (3) percentage of Canadians with a mental disorder who have an unmet mental health care need. In reviewing the provincial and territorial benchmarks and targets, there are several observations:

- Depending on the indicator, some provinces and territories have not listed a benchmark figure or established a target.

- Often, for those provinces and territories who have listed a benchmark they have also identified a modest target (noting that there can be a significant variation in the identified benchmarks and targets).
- Given these rather modest aspirations, can the provinces and territories do more given the crises in access to mental health and substance use health services?
- We are not aware of any discussion and/or consensus amongst the federal, provincial and territorial governments that there should be a series of national or common targets that are evidence-based.
- It will be important to see if each province and territory provides the data that is not listed, and if they meet their proposed targets.

Improving Accountability and System Performance – A Path Forward

CAMIMH recognizes that the work being undertaken by the federal, provincial and territorial governments is extremely important and should be applauded, however, by no means is it complete. Recall that the 2023 (2nd Annual) mental health-substance use health report card released by CAMIMH noted that surveyed Canadians gave their governments a failing grade across the board when it comes to timely access to care. Clearly, there is much more work to be undertaken by governments at all levels when it comes to measuring system performance and reporting to the people of Canada. In the view of CAMIMH, there are four specific areas where more must be done:

1. ***Develop a comprehensive set of mental health and substance use health performance indicators*** – A number of national common indicators have been developed and are very important in terms of their area of focus and will become even more important over time with trend analysis. However, are they adequate in providing Canadians with a comprehensive summary as to how their provincial and territorial mental health and substance use health systems are performing? Are there other common national indicators that either need to be identified which currently exist within the Canadian Institute for Health Information's (CIHI) data holdings (e.g., number of in-patient mental health beds; number of in-patient substance use health beds), or need to be identified and developed (e.g., wait times for in-patient mental health and/or substance use services; hospital stay extended until community supports ready for mental health and substance use cases [alternate level of care days]; first treatment contact for mental health and substance use condition in an emergency department; physician follow-up after hospital discharge for mental health and substance use; proportion of mental health and substance use health patients who report being treated with courtesy and respect)? Clearly, more needs to be done.

   As part of the ***Working Together to Improve Health Care for Canadians*** agreement (Section 6, Performance Measurement) clearly states that the provinces and territories will refine the eight common health indicators in the agreement; that they will work to identify additional common indicators that are mutually agreed upon; and improve reporting on common indicators to measure pan-Canadian progress on improving access to mental health, substance use and addiction services. Moving forward, CAMIMH would be pleased to participate in future indicator selection and development processes.

2. ***Establish evidence-based national targets and benchmarks for each of the mental health and substance use health indicators*** – Can governments develop a series of national evidence-based targets for most or all of the common indicators? While most provinces and territories have provided a benchmark and target for each of the three indicators in the 2023 Agreement, how do we know if they are at the right level, exceeding expected performance or performing below what is expected? We know this approach can work and has been previously undertaken by the federal, provincial and territorial governments in 2005 to address wait times across Canada for five procedures (i.e., cancer, cardiac, diagnostic imaging, joint replacement, and sight restoration). Again, there is more that we can do, using evidence, to assess and improve system performance over time.

3. ***Effectively communicate mental health and substance use health performance to Canadians through a National Mental Health and Substance Use Health Dashboard*** – Another critical element that is a natural complement to the indicator identification and development process is having a user-friendly format in which to communicate the performance of each province and territory's mental health and substance use health system to the public. Each federal-provincial-territorial bi-lateral agreement clearly identifies the importance of reporting to Canadians in an open, transparent, effective and proactive manner on the progress that is being made.

   However, as it stands, the Canadian Institute for Health Information (CIHI) data that is currently available is presented in a disjointed fashion, with the indicators somewhat disconnected from one another and provide us with no ability to assess overall system performance. What is needed is a framework that presents the selected national indicators in a more integrated and user-friendly fashion within and across the provinces and territories. In other words, in the view of CAMIMH, is it possible to develop a **national mental health and substance use health system performance dashboard**? Dashboards are being used with increasing frequency in the health system and other sectors to summarize complex information and would be one way to effectively tell a story about system performance to the public. Similar to the identification, development and public release of patient safety indicators (e.g., a standardized mortality index), this is not about blaming and shaming, but rather, this is about accelerating the sharing of lessons learned and the impact of innovative programs, services and supports that improve system performance; in other words, this is a race to the top, of which all Canadians would benefit!

   Through such investments will we support our mental health and substance use health systems in becoming more open, transparent, innovative, accountable and ultimately – high performing. CAMIMH members look forward to working collaboratively with all governments, and others, in making this a reality

4. ***Ensure the Canadian Institute for Health Information (CIHI) has the long-term funding to fulfill its mandate*** – To accelerate the pace of developing a more robust set of national common mental health and substance use health indicators, governments should be providing CIHI – our national health information data collection and statistical agency – with the long-term resources it requires. At the end-of-the day you cannot manage what you do not measure; the time is long overdue for governments to invest the necessary resources to ensure we have a robust set of national mental health and substance use health system indicators. At the same time, as has been previously pointed out by CAMIMH on a number of occasions, we also need to have a much clearer understanding of how governments, employers and employees and the people of Canada spend their money on mental health and substance use health programs, services and supports. As it stands, in Canada we do not have a comprehensive expenditure framework as part of the National Health Expenditure data series that captures all (i.e., public, community-based, employer and out-of-pocket) mental health and substance use health spending.

In closing, while the provinces and territories have taken the money, many of them are not investing these resources to improve timely access to accessible and inclusive mental health and substance use health care services. This lack of investment will continue to limit the ability of Canadians to access care where and when they need it. There can be no health without mental health. For too long, mental health and substance use health have been the poor cousins of Medicare; avoided, neglected and under-resourced. It is time that we not only invested the resources needed to improve timely access to accessible and inclusive mental health and substance use health services but *developed a meaningful set of comprehensive national indicators* to measure, monitor and manage system performance.

While there has been improvement in the identification of some mental health and substance use health

indicators to measure progress, not all provinces and territories have provided the benchmark and target information, nor are they proposing bold enough targets. While governments need to up their game in terms of reporting on these indicators, they also need to consider developing other evidence-based indicators that would provide a more comprehensive picture of system performance in the mental health and substance use space. To ensure the public can easily understand system performance, CAMIMH recommends that governments develop a ***National Mental Health and Substance Use Health System Performance Dashboard***.

1. Background

On February 7, 2023, following a series of ongoing discussions amongst First Ministers, the federal government announced a ten-year fiscal framework called ***Working Together to Improve Health Care for Canadians***. Over the next decade, the planned value of the Canada Health Transfer is scheduled to increase from $142.054 Billion to $161.4 Billion, or $19.346 billion (13.6%), representing a cumulative total of $186.4 billion. As part of this fiscal framework, the federal government also set aside $25 billion – $2.5 Billion over each of the next ten years – to the provinces and territories to be invested amongst four specific health care priorities, they are:

1. Expanding access to family health services, including in rural and remote areas
2. Supporting our health workers and reducing backlogs
3. ***Improving access to quality mental health and substance use services, and***
4. Modernizing the health care system with standardized health data and digital tools

At various points in time in 2023, the provinces and territories agreed to the ten-year fiscal framework, which provides cash transfers that are to be dispersed on an equal per capita basis. However, to be eligible for their share of the additional annual amount of $2.5 Billion, they needed to sign a formal *Bi-Lateral Agreement* with the federal government to provide a clear sense of accountability as to how the funds were to be invested across the four areas identified above, and how they were to measure progress.

As a result, each province and territory and the federal government signed a *Working Together to Improve Health Care for Canadians* agreement. Each bi-lateral agreement, with the exception of Quebec under the principle of asymmetric federalism, provides details as to how their share of the $2.5 Billion will be invested over the 2023/24 to 2025/26 period, and how they intend to measure progress.[1]

In addition to the $25 Billion, each province and territory has also accounted for their share of the $5 Billion that was provided by the federal government in Budget 2017 over the same 2023/24-2025/26 period. At that time, the federal government announced a ten-year fiscal framework that provided $5 Billion for mental heath and addiction services,[2] and $6 Billion for home and community care. Prior to the 2017 funding agreement, in August 2016 the federal, provincial and territorial governments agreed on a ***Common Statement of Principles on Shared Health Priorities*** which identified objectives, principles to guide action in improving access to home and community care services, and mental health and addiction services.[3] It also underscored the importance of developing a set of common indicators and their public reporting. The Statement concluded by acknowledging the importance of working with and supporting Indigenous communities to address health disparities and access.[4]

2. Purpose

Given the longstanding history of the provinces and territories demanding maximum cash from the federal government for health care with minimal strings or accountabilities, CAMIMH wanted to better understand if the provinces and territories are just taking the money and running, or are they putting their money where their mouths are when it comes to improving timely access to accessible and inclusive mental health and substance use health services? Thus, the purpose of this document is fourfold:

1. To clearly lay out the funding that has been committed by the federal government to the provinces and territories in the 2023 and 2017 agreements for mental health and addictions services from 2023/24 to 2025/26. This includes determining if the provinces and territories have invested the full amount provided to them in the 2017 framework in mental health and addictions, and understanding how much funding from the 2023 Bi-Lateral Agreements is invested across the four specific priorities – with a concentrated focus on mental health and substance use health
2. To identify the provincial and territorial priorities attached to this funding
3. To determine how the provinces and territories will hold themselves accountable in terms of the indicators (benchmarks and targets) they have selected for mental health and substance use health services; and
4. To identify a path forward to improve public reporting on health system performance

While new federal (as well as provincial and territorial) funding is always very much appreciated, taken alone it is only a means unto itself. What is clear is that new funding must be invested in ways that improve and expand timely access to accessible and inclusive mental health and substance use health care services, the overall performance of our health systems and the health and well-being of Canadians. This latter point has been underscored by the Canadian Alliance on Mental Illness and Mental Health (CAMIMH) as it has consistently called for strong federal leadership via new legislation (called a *Mental Health and Substance Use Health Parity Act For All Act*) that recognizes the critical need to expand and improve access to mental health care and substance use health services as we do for physical health through a dedicated envelope of funding (such as a *Canada Mental Health and Substance Use Health Transfer*[5]), and the need to develop a robust set of common or national indicators that measure outcomes and/or performance.[6]

3. Federal Fiscal Framework for Mental Health and Substance Use Health Services, 2023/24 – 2025/26

Table 1 provides a high-level overview of the total amount of federal funding to the provinces and territories over the three-year period for the health care system writ large via the 2023 Working Together to Improve Health Care in Canada framework, and the 2017 funding accord for mental health and addiction services. Note that while in total that $25 billion is from the *Working Together to Improve Health Care for Canadians* Fund and $5 billion is from the Mental Health & Addictions Fund, for 2023/24 to 2025/26, only $9.3 billion has been allocated to the provinces and territories on an equal per capita basis. And of that $9.3 billion, a minimum of $1.8 billion (19%) is guaranteed to be invested in mental health and substance use health services. It is presumed that the remainder of the funding for both agreements will be provided by the federal government to the provinces and territories following further discussion about what has been achieved over the current three-year period.

Table 1

Federal Funding to the Provinces and Territories For the 2023 Working Together to Improve Health Care in Canada Agreements and the 2017 Mental Health and Addictions Accords, 2023/24 – 2025/26

Year	2023 Working Together to Improve Health Care in Canada ($ Billions)	2017 Funding Agreement for Mental Health and Addictions ($ Billions)	Total ($ Billions)
2023/24	2.5	0.600	3.1
2024/25	2.5	0.600	3.1
2025/26	2.5	0.600	3.1
Total	**7.5 (81%)**	**1.8 (19%)**	**9.3 (100%)**

4. What are the Health System Priorities of the Provinces and Territories?

The 2017 accords and 2023 bi-lateral agreements between the federal government and the provinces and territories have broken new ground in terms of the degree of specificity in which the agreements are structured (compared to previous First Minister Health Accords). In the past, dollar amounts have been determined and allocated via the *Canada Health Transfer* (CHT) on an equal dollar per capita basis, with general agreement about provincial and territorial priorities; possibly some earmarked funds that are time-limited and issue-specific have been included; and there could be general reference to measuring and reporting to the public on health system performance.

These two agreements, however, have a greater degree of detail and structure in terms of where the funding will be invested, how the investments will be tracked in terms of measuring progress, how amendments to the agreement can occur, how disputes between levels of government can be resolved, and how the agreement may be terminated. Clearly, all governments, with the exception of Quebec, have responded to the requirements for greater transparency and accountability.

Table 2 provides a high-level summary, by province and territory of how the total federal funding is allocated to each of the four priority areas outlined in the 2023 *Working Together to Improve Health Care for Canadians* agreement, and the funding for mental health and addictions in the 2017 accord.

Table 2

Federally Funded Priorities for Mental Health and Addiction Services from the 2023 Federal-Provincial Bi-Lateral Agreements and 2017 Mental Health and Addictions Accords by Provincial-Territorial Priority Areas, 2023/24 – 2025/26 ($ Millions, and % Distribution)

Priority	Nfld	PEI	NS	NB	Que	Ont	Man	Sask	Alta	BC	YK	NWT	NU	Total
1. Expanding access to family health services, including in rural and remote areas	31.19 (12.2%)	61.76 (65.6%)	144.462 (40.6%)	60.0 (19.1%)	??	102.750 (3.2%)	0 (0%)	71.1 (18.2%)	539.0 (50.6%)	0 (0%)	5.12 (21.8%)	9.2 (42.5%)	13.589 (56.8%)	1,038.17 (14.0%)
2. Supporting our health workers and reducing backlogs	73.97 (28.9%)	24.62 (25.7%)	51.789 (14.6%)	119.1 (37.9%)	??	1,722.0 (53.7%)	368.7 (85.0%)	185.1 (47.4%)	45.0 (4.2%)	891.0 (72.9%)	0 (0%)	3.02 (13.9%)	6.09 (25.4%)	3,490.4 (47.1%)
3. Improving access to quality mental health and substance use services	**48.95 (19.1%)**	**7.8 (8.3%)**	**105.189 (29.6%)**	**46.2 (14.7%)**	**??**	**1,293.0 (40.3%)**	**65.1 (15.0%)**	**81.6 (20.9%)**	**427.0 (40.1%)**	**246.0 (20.1%)**	**18.379 (78.2%)**	**9.45 (43.6%)**	**4.263 (17.8%)**	**2,352 (31.8%)**
4. Modernizing the health care system with standardized health data and digital tools	101.88 (39.8%)	0 (0%)	54.072 (15.2%)	88.2 (28.1%)	??	87.750 (2.7%)	0 (0%)	52.8 (13.5%)	59.0 (5.5%)	84.9 (7.0%)	0 (0%)	0 (0%)	0 (0%)	528.6 (7.1%)
Total	**255.99 (100%)**	**94.18 (100%)**	**355.512 (100%)**	**313.5 (100%)**	**1,886.4 (100%)**	**3,205.5 (100%)**	**433.80 (100%)**	**390.60 (100%)**	**1,070.0 (100%)**	**1,221.9 (100%)**	**23.499 (100%)**	**21.67 (100%)**	**23.939 (100%)**	**9,296.49 (100.0%)**

Several observations can be made:

1. On reviewing each of the federal, provincial and territorial agreements, $9.296 of the allocated $9.3 billion, or virtually 100% has been accounted for.
2. Each province and territory has allocated a different proportion of federal funding across the four priorities. This is not unexpected given that each province and territory may have a different ranking of health priorities, in addition to what they have currently allocated from their own provincial/territorial budgets.
3. While the national average for funding invested in mental health and substance use services stands slightly above thirty percent (at **31.8%**), there is a significant amount of variation across the provinces and territories, with a low of **8.3%** in PEI to a high of **78.2%** in the Yukon. Because Quebec does not specify how it will allocate federal funding, the $1.8 billion dollars has been removed from the "total" denominator calculations (i.e., 9,296.49 – 1,886.4 = $7,410.09). One would note that the median level of investment is **19.6%**.
4. While each of the provinces and territories have clearly identified their respective priorities, given the challenges that exist across the mental health-substance use health spectrum, one wonders why so few have ramped up investment in these critical need areas.
5. There are likely different reasons why some provinces and territories have invested so little in mental health and substance use health. For example, they may not see it as an important priority, or they may be already investing provincial/territorial resources. That said, the current proportion invested by provinces as part of their health budgets is in the 5-7% range,[7] and it has been recommended by the Royal Society of Canada that an investment in the **12%** would be more appropriate,[8] and closer to what other developed countries are allocating (e.g., France [15%] and the United Kingdom [13%).[9]
6. Given the challenges all health systems are facing when it comes to wait times, and the recruitment and retention of health care workers, it is not surprising to see that close to half of the total federal funding (47.1%) is being allocated in this area.
7. Knowing the importance placed on the need for better data to understand how health systems are performing, it is somewhat surprising to see such a low level of investment in developing standardized health data and digital tools (7.1%).

Another way of looking at the two agreements is that we know, by definition, that all of the funding from the 2017 mental health and addictions accord will be spent in this area, however, it would be important to identify how much of the $25 billion from the 2023 Working Together to Improve Health Care for Canadians Agreements is being invested in mental health and substance use health care priorities – Table 3 provides a summary.

Table 3
How much of the 2023 Working Together to Improve Health Care for Canadians Is invested in Mental Health and Substance Use Health Priorities? by Province-Territory, 2023/24 – 2025/26 ($ Millions, and % Distribution)

Priority	Nfld	PEI	NS	NB	Que	Ont	Man	Sask	Alta	BC	YK	NWT	NU	Total
Total amount received from the 2023 Working Together to Improve Health Care for Canadians Agreement	231.66	86.52	308.34	276.09	1,488.0	2,496.18	368.82	335.52	855.45	975.99	21.81	22.08	21.3	7.487
Amount invested in mental health and substance use health priorities	24.65	0.0	58.029	8.7	??	595.905	0.0	26.4	215	0.0	16.369	7.35	1.92	954.368
Percent invested in mental health and substance use health priorities	**10.6%**	**0.0%**	**18.8%**	**3.2%**	**??**	**23.9%**	**0.0%**	**7.9%**	**25.1%**	**0.0%**	**75.1%**	**33.3%**	**9.0%**	**15.9%**

A few observations:

1. On reviewing each of the 2023 federal, provincial-territorial bi-lateral agreements, $7.487 billion of the allocated $7.5 billion, or virtually 100% has been accounted for.
2. Interestingly, PEI, Manitoba and British Columbia have allocated $0 (0%) funding to mental health and substance use health services. In fact, seven of the 12 reporting provinces and territories are allocating **10% or less** of the available bi-lateral funding to mental health and substance use health services.
3. Of the $7.5 billion available over the three-year period (and accounting for Quebec's lack of specifying their allocation of dollars), the provinces and territories are allocating, on average only **15.9%** of the funding to mental health and substance use health services, with the highest proportion being the Yukon (75.1%), Alberta (25.2%), Ontario (23.9%) and Nova Scotia (18.8%).[10] Median funding stands at **8.45%**.
4. Given the crisis of timely access to care for those with mental health and substance use health problems, why are so many provinces and territories investing so little new federal dollars to improve and expand access to mental health and substance use health care services?

This is very concerning given that publicly available data tells us that Canada's mental health investments account for roughly 5% of their health budgets,[11] which is significantly below the recommended 12% by the Royal Society of Canada,[12] which CAMIMH supports. Clearly, there is room to grow our public (federal, provincial and territorial) investments in mental health and substance use health services.

5. How are the Provinces and Territories Measuring Performance and Holding Themselves Accountable to the Public?

To this point, this report focuses only on the magnitude and distribution of federal dollars transferred to the provinces and territories across the four agreed-upon priority areas in 2023, and the 2017 Accord. While order-of-magnitude levels of funding generally signal the priority that a government places on an issue, it is equally if not more important, to have a clear sense of the impact such investments will have on the ground in terms of improving timely access to quality mental health and substance use health care. As part of the 2023 *Working Together to Improve Health Care for Canadians*, the provinces and territories agreed on a series of eight common indicators across the four priority areas, they are:

1. Priority #1: Family health services – Percentage of Canadians who report having access to a regular family health team, a family doctor or nurse practitioner, including rural and remote areas.
2. Priority #2(a): Health workers and backlogs – Size of COVID-19 surgery backlog.
3. Priority #2 (b): Health workers and backlogs – Net new family physicians, nurses, and nurse practitioners.
4. ***Priority #3(a): Mental health and substance use – Median wait times for community mental health and substance use services.***
5. ***Priority #3(b): Mental health and substance use – Percentage of youth aged 12 to 25 with access to integrated youth services (IYS) for mental health and substance use.***
6. ***Priority #3(c): Mental health and substance use – Percentage of Canadians with a mental disorder who have an unmet mental health care need.***
7. Priority #4(a): Modern health data system – Percentage of Canadians who can access their own comprehensive health record electronically.
8. Priority #4(b): Modern health data system – Percentage of family health service providers and other health professionals (e.g., pharmacists, specialists, etc.) who can share patient health information electronically.

Given the focus of this report, Tables 4, 5 and 6 will focus on each national indicator under Priority #3, by province and territory, including the current benchmark measurement (i.e., where we currently are) and the target (i.e., where we would like to be) they would like to achieve.

Priority 3 (a) – Median wait times for community mental health and substance use services

As one measure of quality, having accurate and up-to-date information on how long Canadians are waiting to access mental health and substance use health care is critical. While waiting itself can be measured in different ways (e.g., from first point of contact to care; from day of referral from a family doctor to a specialist; average vs median wait time) and across different settings (e.g., community, primary care, hospital), the Canadian Institute for Health Information, as a starting point, has selected median wait times for community mental health and substance use services.

Table 4
Priority #3(a): Median Wait Times for Community Mental Health and Substance Use Services
Provincial-Territorial Indicator with Baseline Measurement and Target to Achieve
2023/24 – 2025/26

Priority #3: Improving access to quality mental health and substance use services			
Indicator[13]	Province	Baseline	Target
Median wait times for community mental health and substance use services[14]	Newfoundland & Labrador	33 days	32 days (March 2026)
Wait times for community mental health counselling[15]	Prince Edward Island	n/a (data not available	n/a (data not available)
Wait times for community mental health counselling	Nova Scotia	22 days	20 days[16] (2025/26)
Median wait times for community metal health counselling	New Brunswick	62 days	55 days (March 2026)
Median wait times for community mental health and substance use services	Quebec	No baseline identified	No target identified
Median wait times for community mental health and substance use services	Ontario	n/a[17]	Adult: 103 days[18] (March 2024); Child and Youth Mental Health: 62 days[19] (March 2024)
Median wait times for community mental health and substance use services	Manitoba	Under development	Under development[20]
Median wait times for community mental health and substance use services[21]	Saskatchewan	12 days	11 days (March 2026)
Median wait times for community mental health and substance use services[22]	Alberta	19 days (2022/23)	17 days (2026)
Median wait times or community mental health and substance use services	British Columbia	15 days (2021/22)	14 days (2025/26)
Median wait times for community mental health and substance use services	Yukon	6 days (from CIHI report)	5 days[23] (2025/26)[24]
Median wait times for community mental health and substance use services	Northwest Territories	4 days (CIHI, 2020/21)	4 days[25] (March 2026)
Median wait times for community mental health and substance use services	Nunavut	Data unavailable in the territory	Data unavailable in the territory

Some observations:

1. It is important to note that most provinces and territories, with the exception of Prince Edward Island and Nova Scotia, refer to "median" wait times. Median referring to the time where 50% would wait longer and 50% would wait less than the number provided.
2. While these are agreed upon national common indicators, it is striking that five provinces and territories (i.e., PEI, Quebec, Ontario, Manitoba and Nunavut) have not listed a baseline figure, and in the case of PEI, Quebec, Manitoba and Nunavut have not established a target.
3. There is significant variation in the identified benchmarks (4 to 33 days), and targets (4 to 103 days) by the provinces and territories. Why is that the case?
4. For those provinces and territories that have identified a baseline and target, the progress in reducing median wait times for community mental health and substance use services varies from a low of unchanged to two days (i.e., Newfoundland & Labrador, Nova Scotia, Saskatchewan, Alberta, British Columbia, Yukon, Northwest Territories) to a high of 7 days (i.e., New Brunswick). Given these rather modest aspirations, can the provinces and territories do more given the crises in access to mental health and substance use health services?
5. As far as we know, the provinces and territories working with the federal government and the Canadian Institute for Health Information have not determined if a common national target for this indicator is needed.
6. It will be important to watch each province and territory to see if it provides the data that is not included in Table 4, and to see how each province and territory achieves its target.

Priority 3(b) – Percentage of youth aged 12 to 25 with access to integrated youth services (IYS) for mental health and substance use

The Integrated Youth Services Model (IYS) provides youth aged 12 to 25 years of age with integrated and multidisciplinary services that encompass mental health, substance use care and primary care along with a variety of social services, such as housing and educational and/or vocational supports within a convenient youth-friendly setting. These services are provided by clinicians as well as social service providers, family members and youth peers. The focus of IYS is on client-centred, community-based, stepped care that varies in intensity according to the young person's needs, as opposed to a diagnosis.[26]

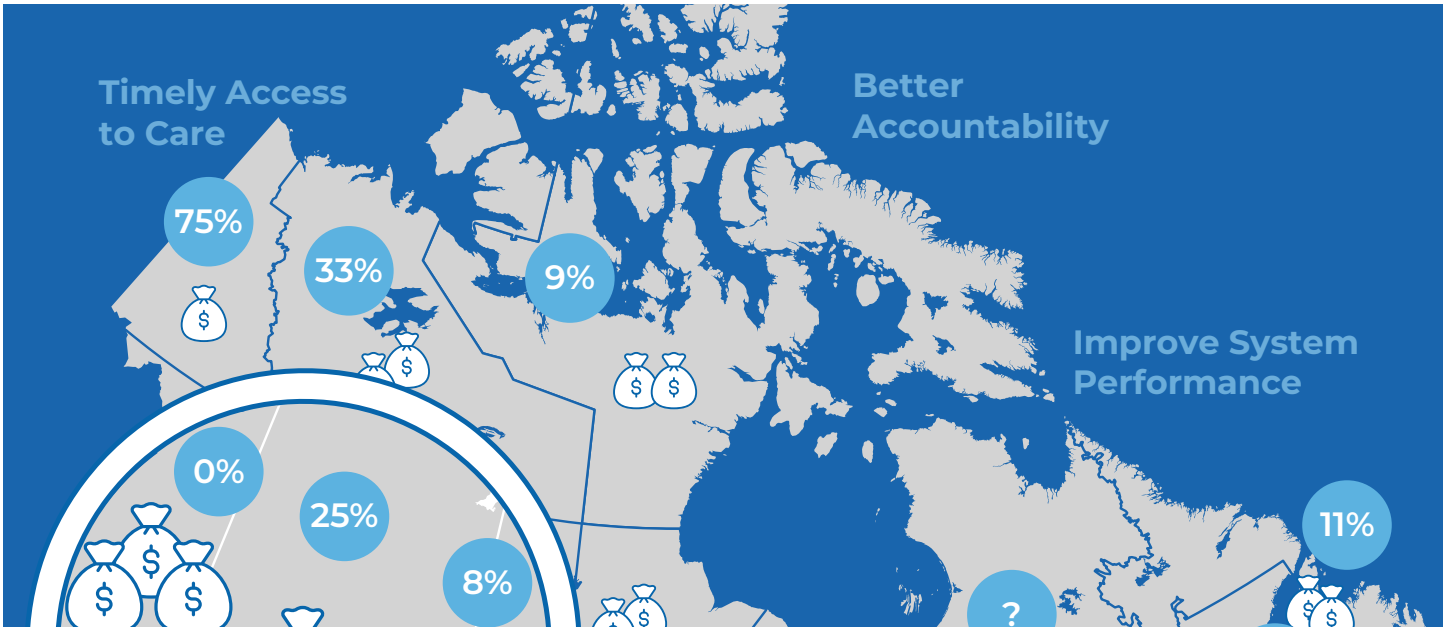


Table 5

Priority #3(b): Percentage of Youth Aged 12 to 25 with Access to Integrated Youth Services for Mental Health and Substance Use Provincial-Territorial Indicator with Baseline Measurement and Target to Achieve 2023/24 – 2025/26

Priority #3: Improving access to quality mental health and substance use services			
Indicator[27]	Province	Baseline	Target
Percent of youth aged 12 to 25 with access to integrated youth services (IYS) for mental health and substance use	Newfoundland & Labrador	1 active site	At least 2 active sites (March 2026)
Integrated youth services availability[28]	Prince Edward Island	n/a	n/a
Integrated youth services (IYS) availability	Nova Scotia	0 sites, 1 under development	3 sites, and 5 under development[29] (2025/26)
Integrated youth services availability	New Brunswick	0	3 (March 2026)
Percentage of youth aged 12 to 25 with access to integrated youth services (IYS)for mental health and substance use	Quebec	No baseline identified	No target identified
Percentage of youth aged 12 to 25 with access to integrated youth services (IYS) for mental health and substance use[30]	Ontario	22 active IYS sites[31] (in total); 8 active IYS sites under development	27 active IYS sites[32] (March 2025)
Integrated youth services availability	Manitoba	6 active integrated youth services delivery sites in 2023	Maintain 6 sites in addition to broader expansions to youth services through 2025/26[33]
Percentage of youth aged 12 to 25 with access to integrated youth services for mental health and substance use[34]	Saskatchewan	0 active sites, and 4 under development	A minimum of 3 IYS sites to be operationalized (March 2026)
Number of youth aged 12 to 25 with access to integrated youth services for mental health and substance use[35]	Alberta	4	102 (2026)
Percentage of youth aged 12 to 25 with access to integrated youth services for mental health and substance use	British Columbia	15 IYS active sites; 9 YHS sites under development (2023)	20 IYS active sites[36] (2025/26)
Percentage of youth aged 12 to 25 with access to integrated youth services for mental health and substance use	Yukon	Not applicable[37]	Not applicable
Number of integrated youth services (IYS) sites for mental health and substance use	Northwest Territories	1 (Ulukhaktok)	1[38] (March 2026)
Percentage of youth aged 12 to 25 with access to integrated youth services for mental health and substance use	Nunavut	Not applicable	Not applicable

Some observations:

1. Over the past few years, a number of provinces have invested in the Integrated Youth Services (IYS) model, however, the general public may not be aware of what the objectives of this model are. For more information on the IYS model please go to Graham Boeckh Foundation website at: www.grahamboeckhfoundation.org. In total, the provinces and territories will go from 49 to 164 active sites (with 102 [or 62%] in Alberta alone) over the next three years. When one looks more closely at the numbers, one sees a modest increase across most provinces (e.g., Newfoundland & Labrador, Nova Scotia, New Brunswick, Manitoba, Saskatchewan), or no increase or baseline or target (i.e., PEI and Quebec).
2. As the driver of IYS delivery models in Canada, the Graham Boeckh Foundation vision is to see a minimum of 110 IYS delivery sites across Canada within a two to three-year period.[39]
3. As far as we know, the provinces and territories working with the federal government and the Canadian Institute for Health Information have not determined if a common national target for this indicator is needed.

4. It will be important to watch each province and territory to see if it provides the data that is not included in Table 5, and to see how each province and territory achieves its target.

Priority 3(c) – Percentage of Canadians with a mental disorder who have an unmet mental health care need

The identification of the percentage of Canadians with a mental disorder who have an unmet need is to quantify the number of individuals who are in need of mental health care treatment, but are unable to access the care they need. The larger the number, the greater the gap between need and access to care. The figures in this section are either provided by the provincial/territorial government or are taken from Statistics Canada's Canadian Community Health Survey.[40]

Table 6
Priority #3(c): Percentage of Canadians with a Mental Disorder Who Have An Unmet Mental Health Care Need
Provincial-Territorial Indicator with Baseline Measurement and Target to Achieve
2023/24 – 2025/26

Priority #3: Improving access to quality mental health and substance use services			
Indicator[41]	Province	Baseline	Target
Percent of Canadians with a mental disorder who have an unmet mental health care need[42]	Newfoundland & Labrador	6%	5% (March 2026)
Percentage of PEI residents aged 12 and over who report a diagnosed mood or anxiety disorder and needs for mental health care not met	Prince Edward Island	7%	7%[43]
Percent of Canadians who report a diagnosed mood or anxiety disorder and needs for mental health care not met	Nova Scotia	10%	9%[44] (2025/26)
Percent of New Brunswickers who report a diagnosed mood or anxiety disorder and needs for mental health care not met	New Brunswick	6%	6%[45] (March 2026)
Percentage of Canadians with a mental disorder who have an unmet mental health care need	Quebec	No baseline identified	No national target identified
Percentage of Canadians with a mental disorder who have an unmet mental health care need	Ontario	7%[46]	TBD[47]
Percentage of people in Manitoba with a mental disorder who have unmet health care needs	Manitoba	8% in 2018[48]	7% by end of 2025/26[49]
Percentage of Canadians with a mental disorder who have unmet health care needs[50]	Saskatchewan	7% (2018)	6.3% (March 2026)
Percentage of Albertans with a mental disorder who have an unmet mental health care need[51]	Alberta	8.7	7 (2026)
Percentage of Canadians with a mental disorder who have unmet health care needs	British Columbia	8% (2018)	7%[52] (2025/26)
Percentage of Canadians with a mental disorder who have unmet health care needs	Yukon	Data unavailable in the territory[53]	Data unavailable in the territory
Percentage of Canadians with a mental disorder who have unmet health care needs	Northwest Territories	Data unavailable in the territory (CCHS, 2018)[54]	Data unavailable in the territory
Percentage of Canadians with a mental disorder who have unmet health care needs	Nunavut	Data unavailable in the territory	Data unavailable in the territory

Some observations:

1. Four provinces and territories either have not identified a baseline or target (i.e., Quebec), or have no available data (i.e., Ontario, Yukon, Northwest Territories and Nunavut).
2. PEI and New Brunswick see no improvement reducing the number of Canadians with a mental disorder who have unmet health care needs, and every other province anticipates marginal improvement. That is, the remaining provinces show very modest improvement with a high of 1.7% (Alberta) to a low of 0.7% (Saskatchewan).
3. Given the crisis in accessing mental health and substance use health care services, how come the provinces and territories are not taking the steps to significantly reduce unmet need?
4. As far as we know, the provinces and territories working with the federal government and the Canadian Institute for Health Information have not determined if there is a need for a common national target for this indicator.

As a complement to the national common indicators that all provinces and territories have agreed to measure progress, the bi-lateral agreements also contain a number of province/territory-specific indicators, which are listed in Table 7. Upon review of the indicators several questions arise:

1. Are their opportunities to identify a more comprehensive series of common national mental health and substance use health indicators (beyond the three that are part of this report) that could be agreed on by the provinces and territories to measure, in a standardized way, how their mental health and substance use health systems are performing?
2. Would a standardized mental health and substance use health system performance framework (with common indicators) promote a greater degree of transparency and accountability in terms of allowing the public to better understand how each province and territory is performing individually, as well as in comparison to one another?
3. Would a common performance framework accelerate the sharing of proven, on-the-ground, innovations across the provinces and territories?
4. Should the provinces and territories create a Canadian Health Innovation Council to support the sharing of lessons learned and innovations across the health sector?[55]

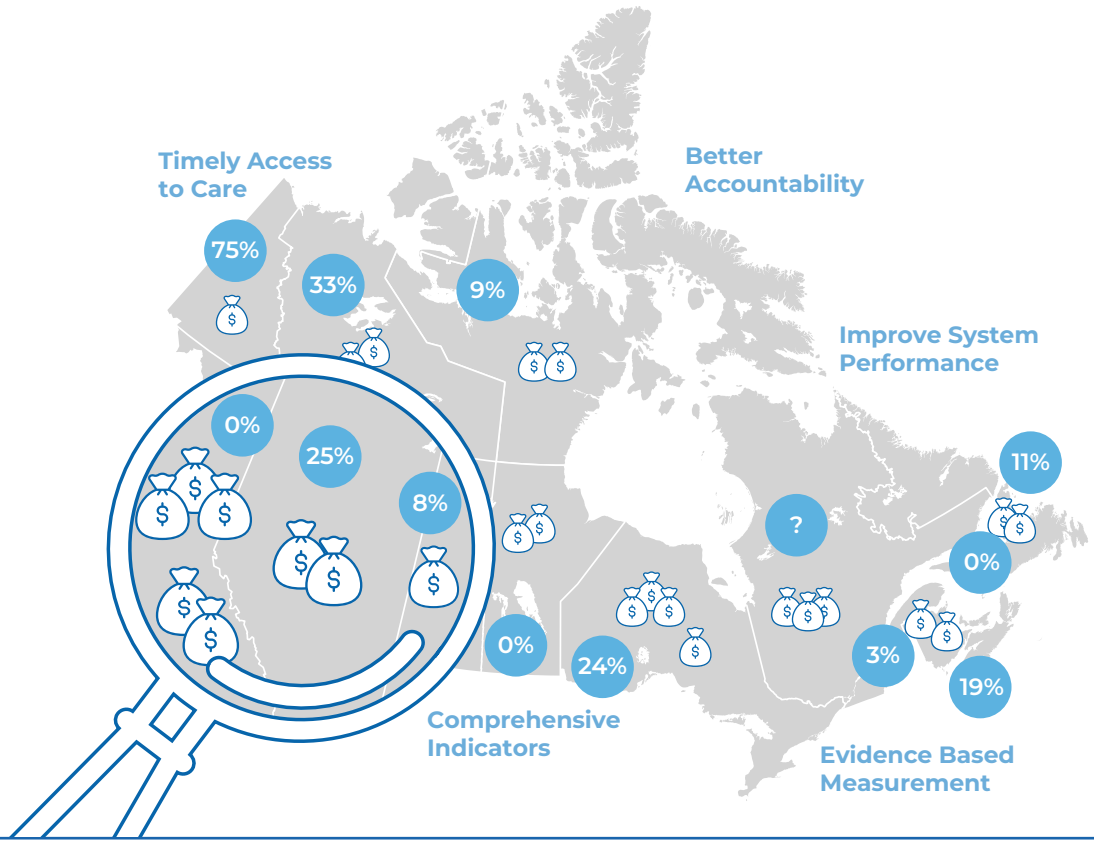


Table 7
Provincial-Territorial Specific Indicators for Mental Health and Substance Use
2023/24 – 2025/26

Priority #3: Improving access to quality mental health and substance use services

Indicator[56]	Province	Baseline	Target
Number of individuals attached to Flexible Assertive Community Treatment (FACT)/Assertive Community Treatment (ACT) teams	Newfoundland & Labrador	As of April 1, 2023, 1,167 people were attached to FACT/ ACT team	Up to a 30 percent increase (1,517) (March 2026)
Number of Doorways[57] locations across the province	Newfoundland & Labrador	As of April 1, 2023, 69 sites across the province	Increase Doorways by 5 (74) (March 2026)
Number of clients seen by mobile mental health (annual)[58]	Prince Edward Island	2,500	5,000 (March 2026)
Percentage of visits to the emergency room with mental health and/or substance use concerns (annual)	Prince Edward Island	8.3%	8.3%[59] (March 2026)
Percentage of MHA wait time within benchmark – non-urgent	Nova Scotia	51.9%	65% (2025/26)
30-day readmission rate for mental health and/or substance use	Nova Scotia	6.9%	5.0% (2025/26)
Median wait time for One-at-a-Time Therapy (in days) – adult	New Brunswick	27.5 days	Less than 10 days (March 2026)
Median wait time for One-at-a-Time Therapy (in days) – child & youth	New Brunswick	23 days	Less than 10 days (March 2026)
Percent of mental health clients hospitalized three (3) or more times in a year	New Brunswick	14.3%	13.5% (March 2026)
Proportion of users who received mental health care and services within the prescribed time frame	Quebec	60%	65% (2024/25); 70% (2025/26); 75% (2026/27)
New clients enrolled in the Ontario Structured Psychotherapy (OSP) program	Ontario	12,281 as of March 2023	17,100 (March 2026)
Number and rate of emergency department (ED visits for mental health and/or substance use	Manitoba	33,053 – number of ED visits; 2,345 – rate of ED visits per 100,000 in 2022/23	2% reduction in the rate of ED visits per year (6% reduction (141) by 2025/26[60]
Increase the number of addiction treatment spaces	Saskatchewan	In 2022/23 there were 475 addiction treatment spaces	By March 31, 2028, add 500 addiction treatment space
First contact in the emergency department (percentage of individuals seen at the emergency department for mental health and addiction-related reasons with no physician health services in previous two years)[61]	Alberta	24.9% (2021/22)	20.8% (2026)
Albertans receiving care at an appropriate level (MHA specific)	Alberta	Under development	Under development
Recovery Capital scores of Albertan communities	Alberta	Under development	Under development
Recovery Capital Index (RCI) scores of Albertans accessing publicly funded addictions or mental health treatment and participating in the My Recovery Platform	Alberta	Under development	Under development
Number of Foundry centres open	British Columbia	16[62]	35 (2025/26)
Percentage of people on Opioid Agonist Treatment (OAT) who have been retained for 12 months	British Columbia	49.9% (August 2021)	2-5% increase[63] (2025/26)
Percentage of people admitted for mental illness or substance use who are readmitted within 30 days	British Columbia	15.4% (2021/22)	13.6% (2025/26)
Implement an Icelandic prevention model (IPM) project in two Yukon communities	Yukon	0	2 (March 2026)
Number of communities with access to community-based withdrawal management	Northwest Territories	0 communities	6 communities (March 2026)
Number of Suicide Prevention Fund recipients each year, by organization	Northwest Territories	9 recipients (2022/23)	10 recipients (March 2026)

For too long, mental health and substance use health have been the poor cousins of Medicare; avoided, neglected and under-resourced. It is time that we not only invested the resources needed to improve timely access to accessible and inclusive mental health and substance use health services but developed a meaningful set of comprehensive national indicators to measure, monitor and manage system performance. Historically, this has been an anathema to the provinces and territories who fear being compared to one another. In the view of CAMIMH, and similar to the identification, development and public release of patient safety indicators (e.g., a standardized morality index), this is not about *blaming and shaming*, but rather, this is about accelerating the sharing of lessons learned and the impact of innovative programs, services and supports; this is about a race to the top, of which all Canadians would benefit!

6. Improving Public Reporting on System Performance – A Path Forward

The work that is being undertaken by the federal, provincial and territorial governments is extremely important and valuable and should be applauded, however, by no means is it complete. Recall that the second annual mental health-substance use health report card released by the CAMIMH noted that surveyed Canadians gave their governments a failing grade across the board when it comes to timely access to care.[64] Clearly, there is much more work to be undertaken by governments at all levels when it comes to access to mental health and substance use health care program, services and supports, measuring system performance, and reporting to the people of Canada.

In the view of CAMIMH, there are four specific areas where more needs to be done: (1) develop a comprehensive set of mental health and substance use health performance indicators; (2) establish evidence-based national targets for each of the mental health and substance use health indicators; (3) effectively communicate mental health and substance use health performance to Canadians through a National Mental Health and Substance Use Health Dashboard; and (4) ensure that the Canadian Institute for Health Information (CIHI) has the long-term funding to fulfill its mandate. Each is discussed in turn.

1. Develop a Comprehensive Set of Mental and Substance Use Health Performance Indicators.

In the context of mental health and substance use health, and building on the *2017 Common Statement of Principles on Shared Health Priorities* and the 2023 Federal, Provincial and Territorial bi-lateral agreements, the Canadian Institute for Health Information (CIHI) developed the following nine common national indicators:

1. Hospital stays for harm caused by substance use (2019)
2. Frequent emergency room visits for help with mental health and substance use (2019)
3. Self-harm, including suicide (2020)
4. Wait times for community mental health counselling (2021)
5. Navigation of mental health and substance use services (2022)
6. Early intervention for mental health and substance use among children (2022)
7. Median wait times for community mental health and substance use services (2023)
8. Percentage of youth aged 12 to 25 with access to integrated youth services (IYS) for mental health and substance use (2023)
9. Percentage of Canadians with a mental disorder who have an unmet mental health care need (2023)

In addition to these indicators, two additional common indicators were announced in 2024:[65]

10. Wait times for substance use services
11. Follow-up after a hospital stay for mental health or substance use.

These national common indicators are very important in terms of their area of the focus and will become even more important over time with trend analysis. However, are they adequate in providing Canadians with a comprehensive summary as to how their provincial and territorial mental health and substance use health systems are performing? Are there other common national indicators that either need to be identified which currently exist within CIHI's data holdings (e.g., number of in-patient mental health beds; number of in-patient substance use health beds), or need to be identified and developed (e.g., wait times for in-patient mental health and/or substance use services; hospital stay extended until community supports ready for mental health and substance use cases [alternate level of care days]; first treatment contact for mental health and substance use condition in an emergency department; physician follow-up after hospital discharge for mental health and substance use; proportion of mental health and substance use health patients who report being treated with courtesy and respect). Clearly, more can be done.

To underscore this point, the Organization for Economic Cooperation and Development (OECD) recommended the following indicators for monitoring the quality of mental health care: (1) hospital re-admissions for psychiatric patients; (2) length of treatment for substance-related disorders; (3) mortality for persons with severe psychiatric disorders; (4) use of anti-cholinergic anti-depressant drugs among elderly patients; (5) continuity of visits after hospitalization for dual psychiatric/substance related conditions; (6) continuity of visits after mental health-related hospitalization; (7) timely ambulatory follow-up after medical health hospitalization; (8) case management for severe psychiatric disorders; (9) continuous anti-depressant medication treatment in acute phase; (10) continuous anti-depressant medication treatment in continuation phase; (11) visits during acute phase treatment of depression; and (12) racial/ethnic disparities in mental health follow-up rates.[66]

As part of the *Working Together to Improve Health Care for Canadians Agreement*, Section 6 (Performance Measurement) clearly states that the provinces and territories will refine the eight common health indicators in the agreement; that they will work to identify additional common indicators that are mutually agreed upon; and improve reporting on common indicators to measure pan-Canadian progress on improving access to mental health, substance use and addiction services.[67] Moving forward, CAMIMH would be pleased to participate in future indicator selection and development processes.

2. Establish Evidence-Based National Targets

An essential piece that requires more discussion and which is absent from the 2017 and 2023 agreements is can we develop a series of national evidence-based benchmarks and/or targets for each indicator? While most provinces and territories have provided a benchmark and target for each of the three indicators in the 2023 Agreement, how do we know if they are at the right level, exceeding expected performance or performing below what is expected? We know this approach can work and has been previously undertaken by the federal, provincial and territorial governments in 2005 to address wait times across Canada. Specifically, governments, using available research and clinical evidence, developed common national benchmarks for the following health services: [68] [69]

1. *Cancer* – radiation therapy to treat cancer (within four weeks)
2. *Cardiac* – benchmark was under development
3. *Diagnostic imaging* – breast cancer screening for women aged 50 to 69 (every two years); cervical screening for women aged 18 to 69 (every three years)
4. *Joint replacement* – hip fracture (within 48 hours), hip replacement (within 26 weeks)
5. *Sight restoration* – cataract removal for high-risk patients (within 16 weeks)

To illustrate this point, a recent report by the Canadian Medical Association recommended that: (1) 80% of 12 to 24 years olds have access to critical mental health and substance use health services,

increasing to 90% within 10 years; (2) knowing that the broader population with an unmet mental health need is 45%, they recommend that this should be decreased to 25% within five years and 10% within 10 years; and (3) when it comes to median wait times for community-based mental health services (see Table 4), we should wait no longer than a maximum of 14 days (within the next five years), and no longer than a week within the next ten years.[70] A more recent report goes on to note that of the last two indicators, only one province/territory has a more ambitious target than the CMA, and three are meeting the CMA target.[71]

It's also worth noting that there were benchmarks developed by the Canadian Psychiatric Association that were part of the 2011 Wait Times Alliance report and were as follows: (1) early psychosis (within 2 weeks); (2) postpartum severe mood disorders (within 4 weeks); and (3) acute/urgent mental health concerns (within 1 week). Regrettably no province was reporting wait times for any of the services.[72] By appealing to the evidence, we can build a more open and responsive mental health and substance use health system.

While CAMIMH understands the importance of identifying in the right mental health and substance use health indicators, having the data to support their measurement, and analyzing the evidence to support the appropriate benchmark(s) and/or targets(s) may take some time, it is a process that governments have already committed to, and should continue to invest in.

3. Effectively Communicate with Canadians – Creating a National Mental Health and Substance Use Health Dashboard

Another critical element that is a natural complement to the indicator identification and development process is developing a user-friendly format in which to communicate the performance of each province and territory's mental health and substance use health system to the public. Each federal-provincial-territorial bi-lateral agreement clearly identifies the importance of reporting to Canadians in an open, transparent, effective and proactive manner on the progress that is being made.[73]

However, as it stands, the CIHI data that is currently available is presented in a disjointed fashion, with the indicators somewhat disconnected from one another and provide us with no ability to assess overall system performance. What is needed is a framework that presents the selected national indicators in a more integrated and user-friendly fashion within and across the provinces and territories. In other words, in the view of CAMIMH, is it possible to develop a ***national mental health and substance use health system performance dashboard***? Dashboards are being used with increasing frequency in the health system and other sectors to summarize complex information and would be one way to effectively tell a story about system performance to the public. Again, CAMIMH would be pleased to contribute to the development of such a dashboard.

4. Ensure the Canadian Institute for Health Information (CIHI) has the Long-Term Funding to Fulfill its Mandate

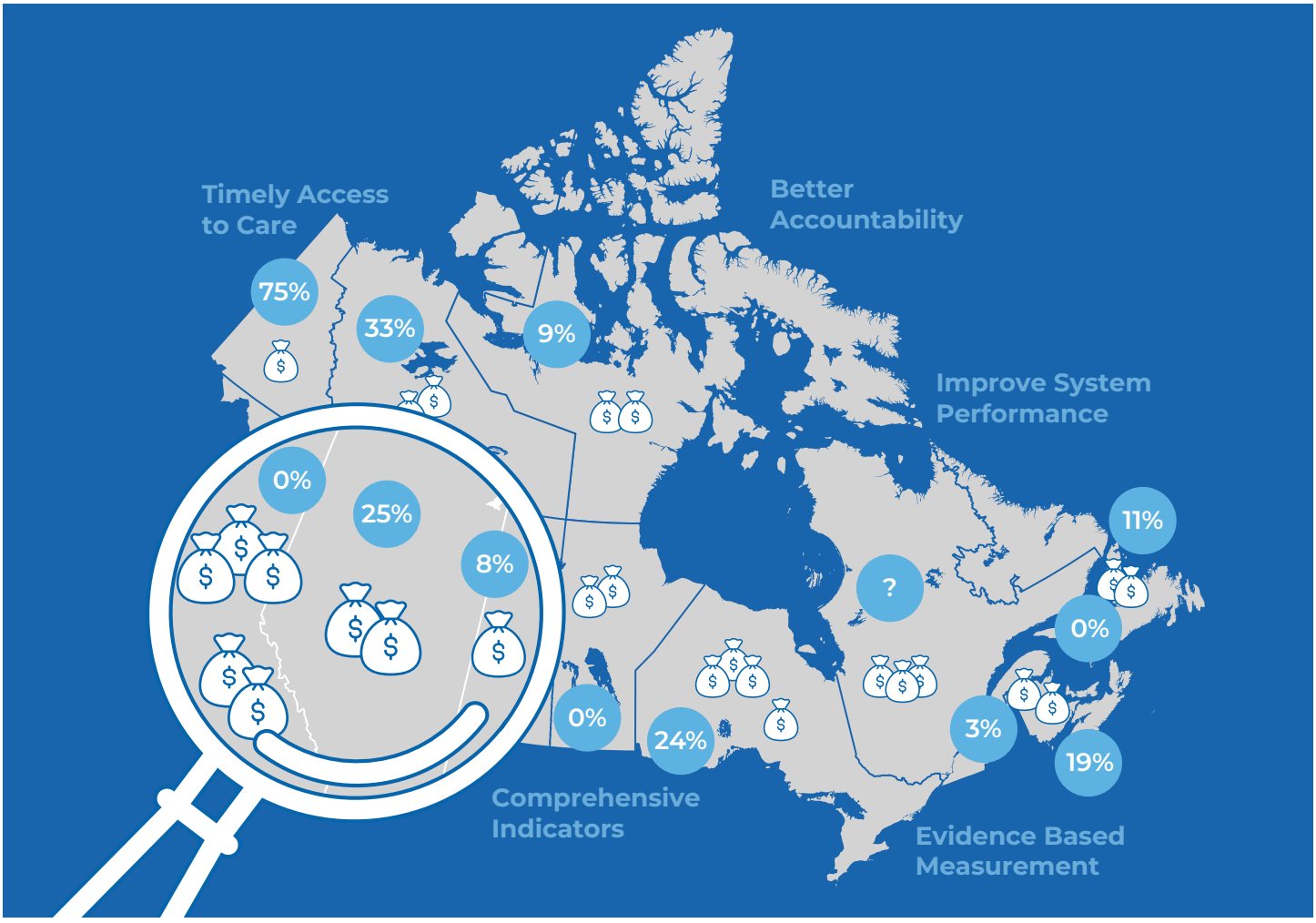
To accelerate the pace of developing a more robust set of national common mental health and substance use health indicators, governments should be providing CIHI – our national health information data collection and statistical agency – with the long-term resources it requires. At the end-of-the day you cannot manage what you do not measure; the time is long overdue for governments to invest the necessary resources to ensure we have a robust set of national mental health and substance use health system indicators. At the same time, as has been previously pointed out by CAMIMH on a number of occasions, we also need to have a much clearer understanding of how governments, employers and employees and the people of Canada spend their money on mental health and substance use health programs, services and supports. As it stands, in Canada we do not have a comprehensive expenditure framework as part of the National Health Expenditure data series that captures all mental health and substance use health spending.[74] This needs to change.

7. Final Reflections

For years, the CAMIMH has been calling on the federal government, and increasingly, the provinces and territories to level the playing field with physical health by significantly increasing their public investments to expand and improve timely access to accessible and inclusive mental health and substance use health services (including the introduction of a new piece of federal legislation called the *Mental Health and Substance Use Health Care For All Act*).

There is no health without mental health, and while governments are recognizing and responding to address our collective mental health and substance use health needs, they are not moving fast enough in terms of integrating mental health and substance use health care programs, services and supports into their respective health systems. At the same time, and as we grow our investments, we must also ensure that we have a clear sense as to how these systems are performing via the development and implementation of common national indicators (as well as understanding how we spend our public and private monies in this space), that can shine a light on pockets of excellence as well as areas that require improvement. By doing so, CAMIMH envisions a process that will encourage a *race to the top* in terms of provincial and territorial health system excellence. Furthermore, only through these investments will we support our mental health and substance use health systems in becoming more open, transparent, innovative, accountable and ultimately – high performing.

CAMIMH members look forward to working collaboratively with all governments, and others, in making this a reality.



References

[1] Each Federal-Provincial-Territorial Bi-Lateral Agreement can be found here: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements.html.

[2] For the remainder of this report, the *terms substance use health services* will be used in place of addiction, which is a term that stigmatizes those who use substances. When the term "addiction" is referred to it is because of the original reference that has been identified in government documents.

[3] The Common Statement of Principles on Shared Health Priorities can be accessed here: https://www.canada.ca/content/dam/hc-sc/documents/corporate/transparency_229055456/health-agreements/principles-shared-health-priorities.pdf.

[4] For an external assessment of the 2017 Mental Health & Addiction fiscal framework by the Canadian Psychological Association, go to: https://cpa.ca/docs/File/Government%20Relations/FMHA%20Overview%202017-18%20to%202021-22%20March%2030%202020.pdf.

[5] Recall that as part of the last federal election, the Liberal Party of Canada promised the establishment of a *Canada Mental Health Transfer*, valued at $4.6 billion over 5 years. Despite the fact that all major national political parties made significant financial commitments to improve and expand access to mental health care services, the sitting government has not delivered on its longstanding promise.

[6] Canadian Alliance on Mental Illness and Mental Health. *From Out of the Shadows and Into the Light – Achieving Parity in Access to Care Among Mental Health, Substance Use and Physical Health*. June 2021.

[7] Institute for Health Economics. *IHE Mental Health In Your Pocket – A Handbook of Mental Health Statistics*. 2019.

[8] Royal Society of Canada. *Easing the Disruption of COVID-19: Supporting the Mental Health of the People of Canada*. October 2020.

[9] Canadian Institute for Health Information. *Health System Resources for Mental Health and Addictions Care in Canada – Chartbook*. July 2019, page 13.

[10] This aggregate figure is confirmed by recent analysis undertaken by the Canadian Mental Health Association entitled *Overpromised, Underdelivered – Analysis of Mental Health Care Investments in the 2023 Working Together Health Bilateral Agreements*, August 2024.

[11] Institute for Health Economics. *IHE Mental Health In Your Pocket – A Handbook of Mental Health Statistics* (2019).

[12] Royal Society of Canada. *Easing the Disruption of COVID-19: Supporting the Mental Health of the People of Canada*. October 2020.

[13] The wording for each provincial indicator is taken verbatim from each federal-provincial-territorial bi-lateral agreement.

[14] On April 1, 2023, Newfoundland and Labrador transitioned to a single provincial health authority and will be adopting a new provincial health information system in the near term. Wait time data collection varied across the former regional health authorities. Provincial changes will impact the current baseline and as such, Newfoundland and Labrador's target is tentative and may be revised to reflect the reporting changes. Source: *Canada – Newfoundland and Labrador Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[15] Data are not currently available on wait times for community mental health counselling. This indicator will be updated as data become available. Source: *Canada – Prince Edward Island Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[16] Nova Scotia government and health partners are working to implement a Universal Menal Health and Addictions Care (UMHAC) system that will improve access to services and resources related to mental health and substance use. As improvements to Nova Scotia's mental health care system continue, this indicator should trend downward. Source: *Canada – Nova Scotia Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[17] Ontario is committed to working with CIHI to establish the baseline and target data for these indicators by March 2024. Source: *Canada – Ontario Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[18] Adult targets are based on high intensity counselling services delivered through the Ontario Structured Psychotherapy Program (OSP) and excludes Bounceback (which the Canadian Institute for Health Information previously excluded from their counselling wait time definition) and clinician assisted bibliotherapy. Source: Canada – Ontario Agreement to Work Together to Improve Health Care for Canadians (2023-24 to 2025/26).

[19] Child and youth mental health (CYMH) projections align with 2022-23 median wait times for counselling services. Please note that counselling was used given the previous definition for this indicator. Source: *Canada – Ontario Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[20] The existing CIHI baseline is not reflective of the current wait times for community mental health and substance use services in the province. Manitoba is developing a standardized reporting process to collect information to measure this indicator in conjunction with work underway with Provincial Information Management and Analytics (PIMA) and CIHI to further define this indicator. Baseline and target will be provided in Q1 of 2024/25. Source: *Canada – Manitoba Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[21] Provincial and territorial data collection systems, 2020. For Saskatchewan results are based on partial data. Source: *Canada – Saskatchewan Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[22] Alberta-specific indicator – New Alberta-specific performance measures are being developed for 24/25 and will be reflected in revisions to the Action Plan as appropriate. Source: *Canada – Alberta Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[23] Underlying goal is to remain among the lowest 5 in the country and below national average. Source: *Canada – Yukon Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[24] Target will be maintained for the duration of the funding period. Source: *Canada – Yukon Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[25] While this target represents the same value as baseline, the Northwest Territories median wait time is already the lowest in Canada. Maintaining this median wait time for the Territory in the face of potential increases in demand tied to the new approaches outline in this Action Plan would be viewed as an overall improvement. Source: *Canada – NWT Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[26] Social Research and Demonstration Corporation. *Integrated Youth Services in Canada – A Portrait*. July 2022. Pages 1-5.

[27] The wording for each provincial indicator is taken verbatim from each federal-provincial-territorial bi-lateral agreement.

[28] PEI is not using federal funding from this action plan for Mental Health and Substance Use initiatives beyond those identified for existing 2017 Common Statement of Principles funding. However, provincial funding will continue to be invested in developing Integrated Youth Services in the province. Source: *Canada – Prince Edward Island Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[29] Nova Scotia has committed to funding eight IYS sites across the province (two per health zone), with the first planned to open in 2023/24. Source: *Canada – Nova Scotia Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[30] As noted in the Canadian Institute for Health Information's August 2, 2023 Snapshot Report, this indicator measures the type and number of IYS sites. Source: *Canada – Ontario Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[31] Please note that these 22 active IYS sites listed include the 8 IYS sites under continued development (i.e., not mutually exclusive). Source: *Canada – Ontario Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[32] Projections based on five IYS sites approved through the paediatric fund being fully up and running by end of next fiscal. Please note that targets will be achieved by March 2025 and sustained thereafter. Source: *Canada – Ontario Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[33] Target to be confirmed in Q3 2024/25. Metrics on increased access to mental health services at integrated youth service sites and number of children served at the sites are also being explored. Source: *Canada – Manitoba Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[34] Ministry of Health data source. In January 2024, the Government of Saskatchewan with the IYS-SK Backbone announced four provincially funded IYS sites. Formerly, one named site operated as an Access Open Minds project until project funding concluded. This Lead Agency is currently developing under the current provincial IYS model. Source: *Canada – Saskatchewan Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[35] National Headline Indicators (Canadian Institute for Health Information). Source: *Canada – Alberta Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[36] Target based on information contained within the Ministry of Mental Health and Addictions 18-month Plan Overview (published April 4, 2023). See page 5. Source: *Canada – British Columbia Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[37] Yukon is not using federal funding from this agreement for IYS sites. Source: *Canada – Yukon Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[38] A this time, there are no additional formal IYS sites under development or planned within the Territory. This target will be revised as needed. Source: *Canada – NWT Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[39] Graham Boeckh Foundation. *Integrated Mental Health Services: A Pan-Canadian Strategy for Supporting Youth & Young Adults*. November 2020.

[40] While the indicator states "*Percentage of Canadians with a mental disorder who have an unmet mental health care need*" (which Statistics Canada measures in the 34-40% range [September, 2023]), some of the wording by the provinces reads "*Percentage of residents with a diagnosed mood or anxiety disorder and needs for mental health care not met*" – appears to be different. Moving forward, some clarity for this indicator is needed.

[41] The wording for each provincial indicator is taken verbatim from each federal-provincial-territorial bi-lateral agreement.

[42] The Canadian Community Health Survey (CCHS) underwent major redesign in 2022, including updated content and methodology. These changes will result in a revised baseline. Based on these changes, Newfoundland and Labrador's target is tentative and may be revised based on 2022 and 2023 data. Source: *Canada – Newfoundland and Labrador Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[43] PEI's aim is to maintain the current percentage considering rapid population growth in the province. Source: *Canada – Prince Edward Island Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[44] The target takes into account that the most recent data available (10%) is from 2018, and it is assumed that this rate could have increased during the pandemic, when many mental health factors worsened. Additionally, this indicator is based on estimates from the Canadian Community Health Survey which has a wide confidence interval of over +/- two percentage points making changes in the estimate over time challenging to accurately measure. Source: *Canada – Nova Scotia Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[45] New Brunswick's aim is to maintain the current percentage considering rapid population growth in the province. Source: *Canada – New Brunswick Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[46] This data, while reported in 2023, is taken from the Canadian Community Health Survey – Annual Component and there is more recent data in "A Mental Health and Access to Care Survey, 2022" released in 2023 which shows 10.7% unmet needs for Canadians. Source: *Canada – Ontario Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[47] Ontario is committed to working with CIHI to establish the baseline and target data for these indicators by March 2024. Source: *Canada – Ontario Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[48] The CIHI baseline is based on estimates from the Canadian Community Mental Health Survey which has a wide confidence interval of over +/- two percentage points making changes in the estimate over time challenging to accurately measure. Survey data may not be fully representative of the current situation in Manitoba. Source: *Canada – Manitoba Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[49] Manitoba is developing a standardized reporting process to collect information to measure this indicator in conjunction with work underway with Provincial Information Management and Analytics (PIMA) and CIHI. Baseline and target will be updated when data becomes available. Source: *Canada – Manitoba Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[50] Statistics Canada. Custom tabulation based on the 2018 Canadian Community Mental Health Survey – Annual Component (CCHS). 2023. Source: *Canada – Saskatchewan Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[51] National Headline Indicators (Canadian Institute for Health Information). Source: *Canada – Alberta Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[52] These estimates from the Canadian Community Health Survey have wide confidence intervals of over +/- two percentage points making changes in the estimate over time essentially meaningless. The impact on confidence intervals of doubling the sample size for future surveys is unknown at this time. Source: *Canada – British Columbia Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[53] Data for the Yukon is currently not included in CIHI reporting. The target will be set once data becomes available. Source: *Canada – Yukon Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[54] Data for the Northwest Territories is currently not included in this section of Statistics Canada's Canadian Community Health Survey (CCHS). Target will be set once data becomes available. Source: *Canada – NWT Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[55] In the past, such a mechanism had been created by the Provinces and Territories, with leadership from their respective Premiers (e.g., Brad Wall [Saskatchewan] and Robert Ghiz [PEI]), however, regrettably this mechanism lost its focus/momentum.

[56] The wording for each provincial indicator is taken verbatim from each federal-provincial-territorial bi-lateral agreement.

[57] Doorways provides rapid access to mental health and addictions counselling "one session at a time".

[58] Includes number of telehealth clinical interventions and number of mobile dispatches by the mobile mental health service. Source: *Canada – PEI Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[59] Three-year average (2020/21 to 2022/23) of visits to Queen Elizabeth Hospital and Prince County Hospital ER with mental health and/or substance use concerns. PEI's aim is to maintain this level considering rapidly increasing population growth within the province. Source: *Canada – PEI Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[60] While a lower rate of emergency department visits for mental health and/or substance use issues is generally seen as indicative of a better performing mental health and addiction service system, the interpretation of this indicator must consider broader access to care, availability of preventive and early intervention services, and overall mental health system capacity and effectiveness which is a direct reflection of government investment in the mental health and addictions system. Source: *Canada – Manitoba Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[61] Alberta-specific indicator – New Alberta-specific performance measures are being developed for 24/25 and will be reflected in revisions to the Action Plan as appropriate. Source: *Canada – Alberta Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[62] Twelve new Foundry centres will be added to provide young people aged 12-24 and their families and caregivers free and confidential services to fit their unique needs. This builds on previous investments that supported the expansion of the Foundry network across the province and the creation of the Foundry virtual services for young people who are not able to access a centre. There are currently 16 Foundry centres open and an additional seven new Foundry centres are in development, for a future total of 35 across the province. Source: *Canada – British Columbia Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[63] Target based on Ministry of Mental Health and Addictions 2023/24-2025/26 Service Plan (published February 2023). See page 11. Source: *Canada – British Columbia Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025/26).

[64] Survey results can be accessed here: https://www.camimh.ca/_files/ugd/db0d0e_e142574173a04142b3c4931440e77922.pdf.

[65] Canadian Institute for Health Information. Shared Health Priorities Indicators, June 2024. July 8, 2024.

[66] Organization for Economic Cooperation and Development. *Focus on Health*, July 2014.

[67] Taken from Section 6.0 (Performance Measurement) of the *Federal-Provincial-Territorial Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025-26).

[68] Government of Canada. *First Ever Common Benchmarks Will Allow Canadians to Measure Progress in Reducing Wait Times*. December 12, 2005.

[69] Health Canada. *Final Report of The Federal Advisor on Wait Times*. June 2006.

[70] Canadian Medical Association. *Improving Accountability in Healthcare for Canadians*. July 2023.

[71] Canadian Medical Association. *Detailed Assessment of Canada's Working Together Plan – A comparative economic and policy analysis of FPT health bilateral agreements in Canada*. June 2024, page 6.

[72] Wait Time Alliance. *Report Card on Wait Times in Canada*. June 2011.

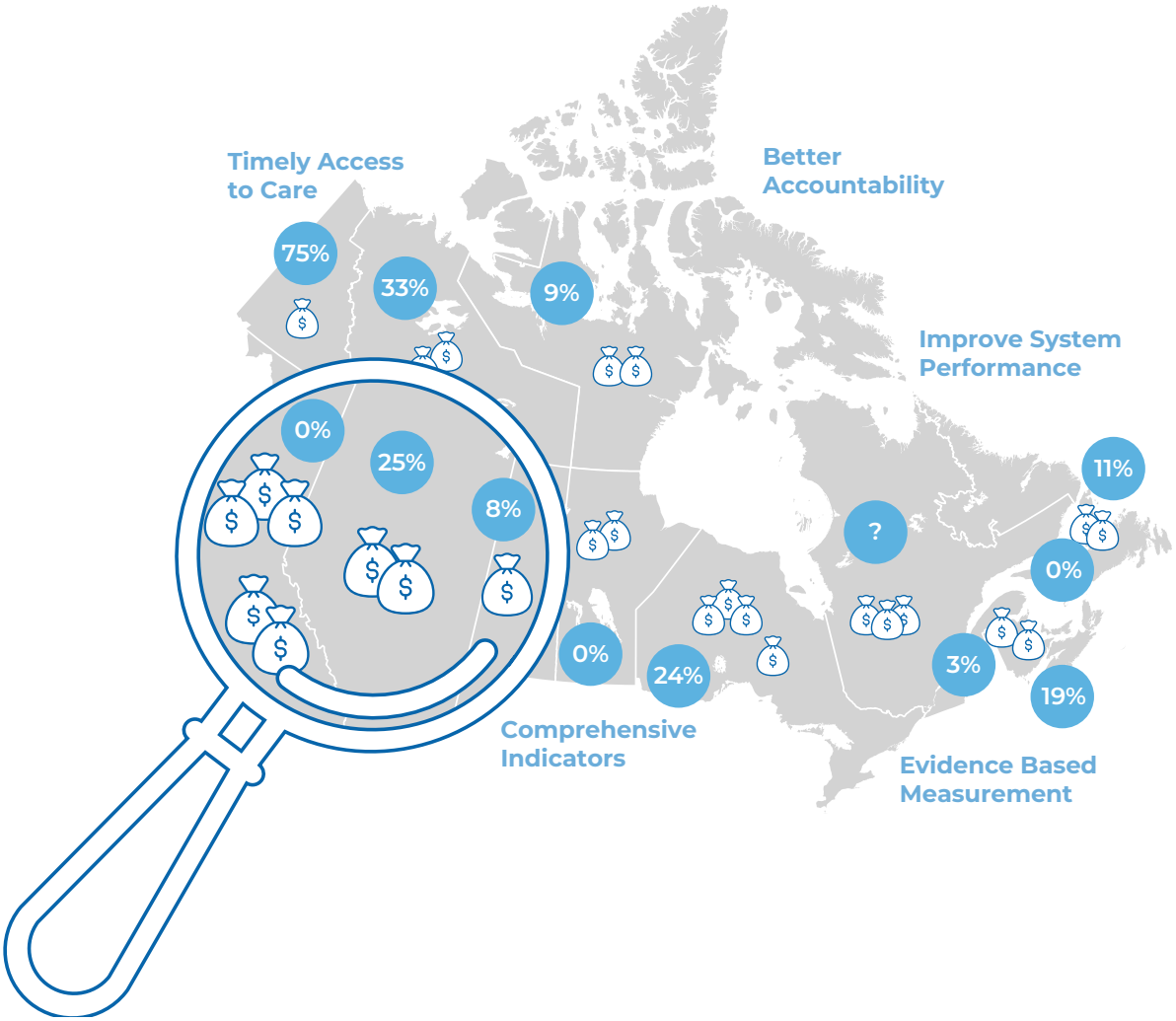
[73] Section Sections 7.0 (Reporting to Canadians) and 8.0 (Communications) of the *Federal-Provincial-Territorial Agreement to Work Together to Improve Health Care for Canadians* (2023-24 to 2025-26).

[74] In its 2025 Pre-Budget submission to the House of Commons Standing Committee on Finance, the Canadian Alliance on Mental Health and Mental Illness (CAMIMH) recommends: "*That the Canadian Institute for Health Information (CIHI) have the necessary resources to work collaboratively with the provinces and territories, and other stakeholders, to develop: (1) a national public, community-based, and private health expenditure data series; and (2) comprehensive mental health and substance use health system performance indicators*."

Take the Money and Run?

How Accountable are the Provinces and Territories in Spending Federal Funding on Mental Health & Substance Use Health Care?

A Review of 2023 and 2017 Bi-Lateral Funding Agreements for Mental Health & Substance Use Health Services, 2023/24 – 2025/26



CANADIAN ALLIANCE ON MENTAL ILLNESS AND MENTAL HEALTH

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