Canadian Mental Health Association
Mental health for all

Association canadienne pour la santé mentale
La santé mentale pour tous

THE STATE OF MENTAL HEALTH IN CANADA 2024

Mapping the Landscape of **Mental Health, Addictions and Substance Use Health**

THE STATE OF MENTAL HEALTH IN CANADA 2024

Canadian Mental Health Association
November 2024

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Suggested citation

Lowe, Leyna, Danielle Fearon, Ammar Adenwala and Deb Wise Harris (2024). *The State of Mental Health in Canada 2024: Mapping the Landscape of Mental Health, Addictions and Substance Use Health.* Toronto, ON: Canadian Mental Health Association.

Contributions

We would like to acknowledge and thank CMHA's National Public Policy Working Group, which is comprised of policy experts representing CMHA local branches, regions and provincial divisions from across Canada, CMHA's National Council of Persons with Lived Experience, and the CMHA National Board of Directors for their feedback and contributions to this report.

CMHA

Founded in 1918, the Canadian Mental Health Association (CMHA) is the most established, most extensive network of community mental health organizations in Canada. Through a presence in more than 330 communities across every province and Yukon, CMHA employs 7,000 staff and engages 11,000 volunteers to provide advocacy, programs and resources that help to prevent mental health problems and illnesses, support recovery and resilience, and enable all Canadians to flourish and thrive.

Land acknowledgement

Located in Toronto, the Canadian Mental Health Association National office acknowledges that we are on the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples and is now home to many diverse First Nations, Inuit and Métis peoples. We also acknowledge that Toronto is covered by Treaty 13 signed with the Mississaugas of the Credit, and the Williams Treaties signed with multiple Mississaugas and Chippewa bands.

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THE STATE OF MENTAL HEALTH IN CANADA 2024:

EXECUTIVE SUMMARY

Canada has signed on to United Nations' International Human Rights Treaties, that commit it to ensuring that **all people in Canada have the right to the highest attainable standard of health and to non-discrimination based on disability**. This includes mental health. However, there is good evidence that we're not meeting our human rights obligations when it comes to mental health in Canada.

The State of Mental Health in Canada 2024 is the first report of its kind: a comprehensive and evidence-based map of the landscape of mental health, addictions and substance use (MHASU) in Canada. It brings together national mental health and substance use health data, reported here as a collection of 24 indicators, and assesses how Canada is doing in supporting the mental health and human rights of its people. While governments have made progress, this report ultimately shows there is a lot of work to do.

This report has three main findings:

1. **Federal funding and policy infrastructure for mental health, addictions and substance use (MHASU) health care are inadequate.** On average, the provinces and territories spend only about 6.3% of overall healthcare budgets on mental health. The 2012 national mental health strategy is stale dated. While the Government of Canada has taken a strong federal role in drug policy by making critical changes to the Drugs and Substance Use Strategy and implementing several legislative changes to reduce the harms of the toxic drug supply, these initiatives receive inconsistent support from the provinces and territories.

2. **Access to mental health, addictions and substance use (MHASU) services and social supports is uneven across Canada.** Access varies across the provinces and territories and people with mental health difficulties and/or mental health-related disabilities experience greater hardships, including inadequate income benefits, access to employment, and housing. The inequities are even greater among racialized and Indigenous populations in Canada, and the rates of suicide, self-harm, and harms due to substance use are very high among First Nations and Inuit communities in the north.

3. **Our measurement of mental health, addictions and substance use (MHASU) health care in Canada is insufficient.** The available national MHASU-related indicators barely scratch the surface of our mental healthcare system. The quality and coverage of the data varies across Canada, with particularly large gaps in the Territories.

This report thus makes a case for stronger federal governance in MHASU funding and policy. The federal government shares responsibilities for Medicare—our free, publicly insured healthcare system—with the provinces/territories. While health care is primarily delivered by the provinces and territories, the federal government plays a critical role in setting the standards for Medicare and providing federal transfers to support its delivery. Shared responsibilities also include social policy such as housing, social services, drug and criminal policy, and income supports. Collaboration and coordination among all levels of government are key to achieving good outcomes in mental health and substance use health and to ensuring adequate funding, strong policies and programs that meet the health needs of the population. A joint commitment to collecting data and measuring and reporting on progress is also essential.

Based on the evidence and findings of this report, we make the following recommendations:

GOVERNANCE AND INVESTMENT

The Government of Canada must strive to invest 12% of health spending in mental health, addictions and substance use (MHASU) health care and create a stronger legislative framework to govern spending. This means:

- Increasing funding for MHASU to $6.25 billion annually so that spending is in line with peer countries, at no less than 12% of the overall healthcare budget.
- Establishing a predictable funding stream and legislative accountability mechanism for mental health either by 1) amending the *Canada Health Act* to explicitly include mental health and substance use healthcare services **or** 2) creating parallel legislation for mental health and substance use health care and a funding transfer that includes robust accountability measures for provinces and territories, and, at a minimum, adheres to the principles of public administration, comprehensiveness, universality, portability, and accessibility.

EQUITY

The Government of Canada must increase social spending and enhance social supports in consultation with people with lived experience of mental illnesses and addictions, so that people with mental health-related disabilities and those experiencing other forms of systemic discrimination have the livable incomes and adequate housing they need to be well. This means:

- Introducing a Universal Basic Income (UBI) program to address poverty. The Government of Canada should consider beginning with three basic income pilot projects, designed to study how a federal-wide program could be administered.
- Reorienting the Canada Disability Benefit (CDB) to serve as a poverty reduction measure and establishing a regulatory framework to ensure that people with mental health disabilities can qualify for the benefit and that they receive enough financial support to live adequately.

EQUITY

- Earmarking federal housing dollars for operating costs for supportive and transitional housing and ensuring collaboration among the provinces and territories to build and sustain more affordable non-market-based housing units.
- Addressing the social inequities experienced by racialized and Indigenous peoples in consultation with those communities to ensure that supports are culturally appropriate and respond to people's needs.

DATA

The Government of Canada needs to collect more and better data to track and improve our mental healthcare system. This means:

- Consulting with people with lived experience of mental illnesses, addictions and substance use disorders, Indigenous Peoples, youth, Black and racialized peoples, and 2SLGBTQ+ and other experts to establish a more comprehensive set of indicators for mental health, addictions and substance use health (MHASU).
- Working with the provinces and territories to strengthen consistent data collection across a comprehensive set of performance indicators.
- Increasing funding to community-based mental health organizations to improve efforts to collect, track, and publicly report on mental health, addiction, and substance use healthcare metrics and ensure that health outcomes from community service delivery are integrated with data collection in the acute and primary health sectors.
- Better supporting northern regions to collect and report data.

It is our hope that the evidence in this report compels decision-makers to act so that people in Canada can enjoy the highest attainable standard of health, no matter where they live, or how much money they have.

HOW WE'RE DOING ON MENTAL HEALTH

AT-A-GLANCE

The state of mental health has gotten significantly worse since the pandemic.

Canadians' mental health is three times worse than before the pandemic and **2.5 million people** can't get the care they need.

An alarming 38% of Indigenous Peoples reported their mental health as "poor" or "fair."

Mental health has been profoundly neglected under universal health care since Medicare was introduced exactly forty years ago.

- Six federal governments in a row have failed to make it right.
- The federal government should either change the Canada Health Act or write a new law with permanent funding that obliges provinces and territories to spend more on mental health and addictions.

Where you live matters.

- People in Canada receive drastically different care depending on their home province or territory.
- Services in the north are often scarce due to a shortage of mental health and addictions workers, including psychiatrists.
- The rate of self-harm in the territories is between 3.5 and 5 times higher than in the rest of Canada.

The toxic drug crisis is out of control.

- 8,049 people died from opioid poisoning in Canada (2023), making the opioid crisis the deadliest in the world after the US, and hitting Western Canada particularly hard.
- Up to two-thirds of drug-related charges are still for possession. People with substance use challenges need social and health supports, not jail time.

No province or territory is spending what it should on mental health.

- On average, provinces and territories are only spending 6.3% of their overall health budgets on mental health when they should be spending 12%.

Paying for cancer treatment is unthinkable in Canada.

- Yet, mental health care often has a price tag and many people have to pay it. If they can afford to.
- With the skyrocketing cost of living, having to buy mental health care can compete with other necessities like food and rent.

It's not a flashy topic, but we need more data!

- You can't fix what you don't measure.
- The report relies on data from official Canadian sources, but the numbers Canada collects barely scratch the surface, especially in the north.

INTRODUCTION:

MAPPING THE LANDSCAPE OF MENTAL HEALTH, ADDICTIONS AND SUBSTANCE USE HEALTH IN CANADA

As a signatory to several United Nations' International Human Rights Treaties,[1] the Government of Canada has committed to ensuring that **all people in Canada have the right to the highest attainable standard of health** and to non-discrimination based on disability. This includes mental health. Health is not merely the absence of infirmity or disease; it is the right to comprehensive mental, physical and social well-being.

However, the evidence in this report demonstrates that Canada is not meeting our human rights obligations when it comes to mental health.

The State of Mental Health in Canada 2024 is the first report of its kind: an evidence-based map of the landscape of mental health, addictions and substance use (MHASU) health care in Canada. It brings together national mental health and substance use health data, reported here as a set of indicators, and assesses how Canada is doing when it comes to supporting the mental health and human rights of its people.

While this report highlights areas where progress has been made, it ultimately shows that there is a lot of work to do.

As Canadians' mental health suffered through the COVID-19 pandemic, the importance of investing in mental health care came to the forefront. Perhaps for the first time in Canadian political history, mental health became a focus of Canadian healthcare policy discussions and was even a key issue in the 2021 federal election. The data presented in this report—some of which span the years of the pandemic—highlight high unmet need for care, uneven access to psychiatrists, and reliance on hospital care for mental health and substance use problems, as seen through elevated readmission rates to hospital. We have not significantly reduced suicides across Canada and have witnessed an alarming increase in deaths attributed to opioid and stimulant toxicity. The evidence here shows that mental health, addictions and substance use health care isn't the priority it should be and points out areas where more must be done.

Care for mental health, addictions, and substance use health is not a priority in Canada.

Importantly, the research shows the critical need for both robust policy frameworks and investments in mental health. Our analysis includes three main findings:

1

Federal funding and policy infrastructure for MHASU are inadequate. Although an OECD report recently estimated Canada's spending on mental health to be around 9%, the calculations from provincial and territorial budgets presented here estimate that spending, on average, is closer to 6.3%. This is below what many peer countries are spending and also well short of the recommended 12%.[2] With the 2012 national mental health strategy[3] now well out of date, the future of Canadian mental health policy remains ambiguous. Although the Government of Canada has taken a strong federal role in drug policy by making critical changes to the Drugs and Substance Use Strategy and legislating changes to reduce the harms of the toxic drug supply, support for these initiatives has been inconsistent among the provinces and territories.

2

Access to MHASU services and social supports is uneven across Canada. Access varies across the provinces and territories and people with poor mental status and/or mental health-related disabilities experience greater hardships, including inadequate income benefits, access to employment, and housing. The inequities are even greater among racialized and Indigenous communities in Canada, and the rates of suicide, self-harm, and harms due to substances are very high among First Nations and Inuit communities in the north.

3

Our measurement of MHASU health care in Canada is insufficient. The available MHASU-related indicators barely scratch the surface of our mental healthcare system. Nationally, we do not collect data across an adequate set of indicators to allow tracking of system performance and access to care, especially when it comes to community mental health services. Gaps in data collection across provinces and territories limit data coverage and quality on a national scale. The data from Canada's northern regions are especially sparse, which is of concern given the health inequities between Canada's Indigenous and non-Indigenous populations.

> **"What cannot be evaluated and measured cannot be improved."[4]**

This report thus makes a case for stronger federal governance when it comes to MHASU funding and policy. It argues that such a role falls well within the scope and responsibilities of the federal government. Recommendations for action are outlined in the conclusion.

In Canada, health care is a shared responsibility across levels of government. The federal government is responsible for investing in and creating legislation for First Nations' and Inuit health and veterans' health. Responsibilities for Medicare—Canada's free, publicly insured healthcare system—are shared between the federal government and the provinces/territories. At the federal level, the *Canada Health Act* sets the standards and rules for the publicly funded healthcare system and the federal government provides a transfer of funds to the provinces and territories for adhering to the standards set by the Act. Provinces and territories use these transfers, along with their own revenues, to manage, organize and deliver health care through their insurance plans.

This system of health governance has been detrimental for mental health. That's because Medicare does not explicitly include mental health, addictions and substance use health care. While the *Canada Health Act* includes mental health services delivered in hospitals or by physicians, it does not require provinces and territories to cover any other mental health, addictions or substance use health service. This is a problem because many of these services are delivered by psychologists, psychotherapists, social workers and in community mental health organizations. All provinces and territories fund some level of public mental health and addictions health services, but the public resources dedicated to mental health are often insufficient to meet the need. Chronic underfunding of mental health and substance use health care means that government-funded services typically serve only a fraction of the population. Everyone else is left to pay for services themselves or through private or employer insurance, if they have it. Those who are not covered and cannot pay often do not get the care they need.

Care for mental health goes far beyond healthcare services alone. It crosscuts other areas of shared responsibility such as housing, social services, drug and criminal law and policy, and income supports. While the provinces and territories primarily provide the services, creating their own policy frameworks and funding structures to support their social services infrastructure, the federal government also shapes these through legislation, frameworks and strategies, policies, and programs. Take housing, for example. Although housing is traditionally an area of provincial and territorial responsibility, the federal government controls some housing policy affecting the cost and availability of homes in Canada. It also introduced a National Housing Strategy with funding to provinces and territories, municipalities and community organizations to build more affordable homes or community housing. Furthermore, the federal government has recognized that adequate housing is a fundamental human right in the *National Housing Strategy Act*, stating that "access to affordable housing contributes to achieving beneficial social, economic, health and environmental outcomes" in line with its obligations under the International Covenant on Economic, Social and Cultural Rights.[5]

Achieving positive mental health and substance use health outcomes thus requires good governance and policy coherence and coordination among all levels of government. This will ensure adequate funding; strong policies and programs that meet the health needs of the population; a commitment to collecting and measuring data; and reporting on progress. In publishing this report, we hope that decision-makers will take action to improve the state of mental health in Canada. To this end, this is the first edition of a report that will be published every two years.

METHODOLOGY

The Canadian Mental Health Association (CMHA) created this report to map the landscape of mental health and substance use health in Canada. The goal is to assess how Canada is doing collectively as a country: are we upholding human rights when it comes to health, equality and non-discrimination; promoting MHASU health and wellness; and providing access to services? We did this by selecting performance measures, sourcing and analyzing national-level data on these measures, and then breaking them down by province and territory to see how they compare to the national average. As such, this report is organized into "profiles": one for Canada and one for each province and territory.

While this report rests on the quantitative national health data collected by organizations such as the Canadian Institute for Health Information (CIHI), the Public Health Agency of Canada (PHAC), and Statistics Canada, each profile is accompanied by a qualitative analysis that provides context for and elaborates on the quantitative data.

It is important to note that, for several reasons, we did not base this analysis on international comparators. First, healthcare systems are structured differently, making comparisons among countries difficult. Second, there are no internationally agreed upon benchmarks for mental health performance measurement. Finally, there are significant variations in how jurisdictions set parameters for data collection on a given indicator and how they go about collecting and reporting on that data. Because of these challenges, international comparators are only used in the qualitative analysis in our profile of Canada and need to be read with great caution due to the differences among jurisdictions.

There are a total of 24 indicators in this report, which are grouped into 5 categories (Table 1):

1. **Government leadership/ governance: MHASU Policy and investment**

2. **Population mental health**

3. **Access to mental health, addictions and substance use (MHASU) health services**

4. **Social Determinants of Health**

5. **Stigma, discrimination and mistreatment**

Table 1. Indicators

1. POLICY

- **1.1a** MHASU Healthcare Investments
- **1.1b** Bilateral Health Spending for MHASU
- **1.2** MHASU Strategy
- **1.3** Decriminalization policy
- **1.4** Harm reduction policy
- **1.5** Mental Health Acts

2. POPULATION MENTAL HEALTH

- **2.1** Perceived Mental health – poor/fair
- **2.2a** Prevalence of mood/anxiety disorder (12-month)
- **2.2b** Prevalence of Substance Use Disorders (lifetime)
- **2.3** Rate of death by suicide
- **2.4** Rate of hospitalization for self-harm
- **2.5** Rate of apparent opioid toxicity deaths
- **2.6** Rate of hospitalizations caused entirely by alcohol

3. ACCESS TO MHASU SERVICES

- **3.1** Percentage of population needing mental health care but needs are unmet or partially met
- **3.2** Percentage of youth with early MHASU service needs who accessed community mental health services
- **3.3** Number of psychiatrists per 100,000 population
- **3.4** Supply of MHASU healthcare providers
- **3.5** 30-day hospital readmission rates for MHASU concerns

4. SOCIAL DETERMINANTS OF HEALTH

- **4.1** Percentage of population reporting poor-to-fair mental health in core housing need
- **4.2** Poverty rate
- **4.3** Employment rate for individuals with mental health disabilities (ages 25-64)

5. STIGMA AND DISCRIMINATION

- **5.1** Percentage of those with poor-to-fair mental health who experienced discrimination and victimization
- **5.2** Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community
- **5.3** Reported rate of drug-related offences

Indicator selection

We selected the indicators for this report based on several criteria. We considered: 1) which health data were available and relevant for understanding access to MHASU care and for supporting human rights in Canada; 2) how recently they were collected and published; 3) whether they could be analyzed by province and territory and compared across these jurisdictions; and, 4) whether the data were of good quality.

This work began by identifying which indicators are used in Canada and internationally to assess population mental health and access to MHASU care. We looked at the performance measures used by organizations such as the World Health Organization (WHO), the Organization for Economic Cooperation and Development (OECD), the National Institute for Clinical Excellence (NICE), Mental Health America (MHA), and Health Quality Ontario (HQO, now part of Ontario Health), among others. We also assessed academic publications (meta-analyses and scoping reviews) to determine which performance measures are widely accepted and used. We found international consistencies in indicator selection and reporting, and in many cases, consensus that the indicators are valid measures for assessing health system performance.

Next, we did a scan to determine what MHASU data were available at the national level in Canada. To be considered for inclusion, data had to have been collected after 2017 and disaggregated (broken down) by province and territory.

This report also includes several indicators that are supported by qualitative data. These qualitatively based indicators are grouped into the first category, *MHASU Funding and Policy*, and pertain to health systems governance, including provincial and territorial health policies, strategic frameworks, and funding decisions. These play an important role in shaping population mental health and access to services across Canada. We collected this data by scanning government websites and publications, budget estimates, bilateral health funding agreements, mental health legislation, and news articles, and we assessed each province and territory's governance policies by establishing criteria for strengths and weaknesses of each policy or legislation (see Appendices).

Exclusions and limitations

Given the serious gaps in national, provincial and territorial data, the indicators in this report do not allow for a complete picture of the state of mental health in Canada. The Government of Canada has taken some steps to improve the performance measurement of MHASU and health care in Canada,[6] but the gaps are still considerable, especially when it comes to service delivery in settings outside of hospitals and physicians' offices, such as community mental health organizations. For instance, we excluded a critical indicator, "Wait times for community mental health counseling," because the data coverage was inconsistent. Data for this indicator is collected yearly, yet in the 2023 data collection cycle, there were no data for Ontario, Québec, PEI, Northwest Territories or Nunavut, only partial coverage for Saskatchewan, Manitoba and British Columbia and incomplete coverage for Alberta. Furthermore, even with consistent coverage, these data would have additional limitations: the definition of "community mental health" for this indicator does not include data from community mental health organizations that are *not* publicly funded or from third-party organizations that are contracted to provide publicly funded services.[7] There are also other performance measurement indicators that are either not consistently collected nationally, or the data are not publicly available. Indicators are not publicly accessible for the availability of mental health promotion programs; rates of involuntary admission and treatment under *Mental Health Acts*; prevalence of mental illness and substance use problems among those incarcerated in federal, provincial and territorial prisons, and prevalence of MHASU disabilities among those who are unhoused. Despite the limitations, however, the indicators and data presented here provide a foundation for identifying problems or weaknesses in our healthcare systems, which can help determine how to improve population mental health and access to care across the country.

Another problem with MHASU data in Canada is that they are not consistently collected and published at a national level. Due to these limitations, we were sometimes limited to working with older data, some of which were collected before the pandemic, that might differ from current trends. Because of this, we were sometimes unable to observe and discuss longitudinal trends.

Although there were enough data to make comparisons among the provinces and territories for some indicators, there are missing data for others. In those cases, we added a note that data were unavailable or insufficient ("Ins."). The full data tables, which include the raw data for each indicator, are available in the Appendices. More detailed notes about data limitations for each indicator can also be found in the Appendices.

Data were cleaned and analyzed using a variety of software, including SAS 9.4, Excel, and SPSS, depending on the format of the data.

Across provinces and territories, variation in geography exists (i.e., varying population size and distribution of services). For demographic or population-based surveys, the proportion of those surveyed and number of respondents were included. When data were available, provincial or territorial population estimates were used to report or calculate standardized rates (e.g., age standardized or crude rates per 100,000). Standardized rates provide more meaningful comparisons across provinces and territories. Other descriptive statistics such as median days or crude rates were reported from publicly available data.

Readers will note that there are substantial data gaps for the territories—Yukon, Northwest Territories and Nunavut—and that unique considerations must be kept in mind when assessing the MHASU landscape in the north.

Yukon, Northwest Territories and Nunavut are distinct places with their own local histories, populations, languages, policies and healthcare systems. They also share commonalities in population needs and challenges in social services and infrastructure that cannot be understood in isolation from the history of colonization and colonial government policy that shaped these regions. The territories are classified as remote and largely rural, but have three urban centres—Whitehorse, Yellowknife and Iqaluit.[8] There are also more Indigenous Peoples in the territories relative to the overall population: Indigenous Peoples make up four-fifths of the population of Nunavut, half of the Northwest Territories, and over one-fifth of Yukon, and these populations overall are younger and growing more rapidly than the non-Indigenous populations.[9] Indigenous communities in the north have been impacted by the *Indian Act*, residential schooling, forced relocations from development projects and resource extraction, among other colonial policies aimed at cultural erasure and assimilation, which have created health and socio-economic disparities between northern Indigenous Peoples and the non-Indigenous population.

While Yukon, Northwest Territories and Nunavut each have territorial governments, a strong modern history of First Nations' and Inuit self-governance in these regions has paved the way for communities' self-determination in delivering programs and services and managing lands, businesses, and health care.[10]

In the territories, certain indicators are not yet measured or publicly available because population sample sizes are too small to report or may pose re-identification risks. Based on available data, the territories tend to underperform when compared to the provinces, particularly when it comes to hospitalization rates, self-harm and rates of poverty and housing need. These are health justice issues for Canada's Indigenous peoples. The health systems performance gap between the north and the rest of Canada speaks to the deep health disparities between Canada's Indigenous and non-Indigenous populations. The absence of data, despite these alarming disparities, suggests a strong need to support northern regions in performance measurement initiatives. These must be undertaken in partnership with Indigenous communities to ensure that population health needs and service access are being tracked in ways that reflect the cultures and values of Indigenous communities.[11] Assessing equity in access also means considering whether care is culturally appropriate, trauma-informed, and culturally safe. Currently, this is not captured by national health performance indicators.

Finally, some of the data included in this report were collected during the COVID-19 pandemic (2019-2023), which may either inflate or underrepresent some of the indicators. Whenever multi-year data is available, we address any inflation or underrepresentation with a qualitative reflection on how it is situated within longitudinal trends.

UNDERSTANDING THE INDICATORS

The following section provides a rationale for, and description of the indicators included in this report. As shown below, we discuss the relevance of the indicators for health systems performance measurement.

1. GOVERNANCE AND POLICY

Good governance is an important part of any high-performing healthcare system. Good governance begins with the actions of governments to establish a strategic vision for the health sector and to uphold and introduce policies, laws, or guidelines that are evidence-based and to which they are held accountable.[12] When we talk about governance, we are talking about how well governments finance the healthcare system; the extent to which they collect data and report on health systems performance; the strength of the MHASU policies that support the programs and services; how governments plan for and resource the MHASU sector; and the strength of laws that support the health, well-being and human rights of the people who live here. We can measure governance in a number of ways; for instance, by assessing the presence, absence, and strength of healthcare policies; how transparent governments are about healthcare plans and decisions; whether they are consultative; and how well they hold themselves accountable. Governments also practice good governance when they respond to and adjust policies to meet population health needs.[13]

Given the importance of governance for assessing health system performance, this report considers a small selection of related indicators, which include:

	Indicator	Description
1.1a	**MHASU Healthcare Investments** (2024-2025)	Assesses the % of provincial/territorial investment in MHASU in relationship to the overall healthcare budget using the 2024-2025 Budget Plans. "Investments" here refers to the operational budgets for MHASU, capital grants as well as new funding announcements published in the 2024-25 budget plan. A higher percentage is more desirable.
1.1b	**Bilateral Health Spending for MHASU** (2023)	Assesses the % dedicated to MHASU in the new 2023 Working Together Agreements and the remaining MHASU funds from the 2017 Shared Health Priorities Agreement. This analysis is based only on the agreement plans that have been announced, which are only for the years 2023-2026. A higher percentage is more desirable.

1.2	MHASU Strategy	Assesses whether there is a dedicated and current MHASU strategy in place and if the Province/Territory (PT) has outlined goals, provided funding support and outlined an accountability framework to support its implementation. This indicator is assessed using the following ratings: Out of date, somewhat comprehensive, moderately comprehensive, highly comprehensive. A "highly comprehensive" rating is most desirable.
1.3	Decriminalization policy	Indicates the presence/absence and strength of legislation removing criminal penalties for simple drug possession (federal only). This indicator is assessed using the following ratings: Low, moderate, high, and very high support. A "very high support" rating is most desirable.
1.4	Harm Reduction policy	Indicates the presence or absence of PT support for harm reduction (communicated in policy statements, the presence of a centralized program, funding support) for the following services: Naloxone, Supervised Consumption Services (SCS)/Overdose Prevention Services (OPS)/ Consumption and Treatment Services (CTS), drug checking, and safer supply. Note: This indicator does not report on the extent to which programs or services are available (it does not assess the number and distribution of services, ease of access, etc.). This indicator is assessed using the following ratings: Low, moderate, moderate-to-high, and high support. A "high support" rating is most desirable.
1.5	Mental Health Acts	Assesses whether the Acts have been recently modernized or amended and whether they have been flagged for possible human rights violations by PT Ombudspersons or human rights groups. This indicator is assessed using the following ratings: Low concern, moderate concern, high concern, and very high concern. A "low concern" rating is most desirable.

2. POPULATION MENTAL HEALTH

When we talk about the rates of mental well-being or mental illness in Canada, we are talking about our population mental health. Population mental health measures mental ill-health and positive states of mental health[14] and assesses the distribution of illness, wellness, and psychiatric disorders within and across society.[15] Understanding the prevalence of mental illnesses and distress is important not only because of the health implications for individuals, but also because it provides insight into the possible impact on families, society, the health system and the economy. For instance, the rates of suicide, depression, mental distress or life satisfaction, which are based on data collected through health and social surveys, all tell us something about the state of mental health and wellness of the population in Canada and how well our healthcare system is responding to need. It can also help steer healthcare policy and funding decisions.

The population mental health indicators found in this report include:

2.1	**Perceived mental health – poor or fair** (% of people **aged 18 and older)** (2021)	A subjective measure of population mental health status. While perceived mental health isn't the same as a diagnosis for a mental illness and doesn't necessarily reflect the prevalence of mental illnesses in a population, this is a valid measure to track given that perceptions of poor mental health have been correlated with physical health problems, increased health and social service use and social determinants like low-income.[16] The survey from which this indicator is derived contains population exclusions, as it was limited to non-institutionalized persons aged 18 and older and did not include those living on reserves. Lower rates of "poor" or "fair" mental health are more desirable. Lower rates indicate better perceived mental health in the population.
2.2a	**Prevalence of mood and anxiety disorders (previous 12-months)** (2022)	Captures the % of the population in Canada aged 15 and older that met the diagnostic criteria for some of the most common mental disorders, including mood, anxiety and substance use disorders (SUDs). The rates of mood and anxiety disorders are for the previous 12 months, and the rate of SUDs reports lifetime prevalence.
2.2b	**Prevalence of substance use disorders (lifetime prevalence)** (2022)	Lower rates are more desirable as they indicate lower prevalence of mood, anxiety, or substance use disorders in the population.
2.3	**Rate of death by suicide (rate per 100,000 people)** (2021-2022)	Indicates the reported rate of death by suicide per 100,000 people. A lower rate is better. Lower rates may indicate better access to community-based care for mental health.

	Indicator	Description
2.4	**Rate of hospitalization due to self-harm (rate per 100,000 people aged 10 years and older)** (2022)	Indicates the rate of hospitalization for self-harm per 100,000 people aged 10 years and older. Self-harm refers to the harm a person does to themselves on purpose, no matter the reason. Self-harm hospitalization statistics are an underestimation of the actual rate of self-harm, given that cases can be overlooked if they are presumed to be accidental or undetermined. Lower rates are better and may indicate better access to community-based care for mental health.
2.5	**Rate of apparent opioid toxicity deaths (rate per 100,000 people)** (2022)	Indicates the number of apparent opioid toxicity deaths per 100,000 people. This indicator provides critical insight into the harms associated with substance use at the population level in the context of the unregulated toxic drug supply. We say “apparent opioid toxicity deaths” because the reported rates include both deaths where an opioid was involved (confirmed) and cases where opioid involvement is still being investigated. This indicator does not include deaths due solely to a stimulant. Lower rates would indicate fewer deaths resulting from opioid toxicity.
2.6	**Rate of hospitalization entirely caused by alcohol (rate per 100,000 people)** (2022-2023)	Indicates the rate of hospitalization due to conditions wholly attributable to alcohol per 100,000 population. Harmful use of alcohol is associated with a range of health conditions that can lead to death, disease or disability. This indicator provides insight into a portion of the harms caused by alcohol and also hospital use due to alcohol harms. It can potentially inform service needs in education, prevention, and treatment for harmful alcohol use. This indicator does not capture hospitalizations for conditions partially attributable to alcohol (e.g., cancers, strokes, respiratory diseases) and because it relies on the documentation of alcohol as the cause of a disease condition, the rate may be underreported.

3. ACCESS TO MHASU SERVICES

In a well-functioning healthcare system, people have access to comprehensive and high-quality mental health and substance use health services when and where they need them. In such a system, people don't wait for long periods to access services and they are able to get appropriate care in their community, free of financial, organizational, and geographical barriers. A key component to enabling access to services is ensuring a fit between the health resources available and the needs of the population.[17]

Commonly used performance measures that assess MHASU service access include data on wait times; met and unmet need for services; and service use data such as rates of hospitalization and repeat emergency department visits, all of which are important indicators that tell us where our health system might be performing well—or not—when it comes to meeting the population's MHASU healthcare needs. For instance, service access data can signal a shortage of preventative and early intervention services, problems with the coordination of services or continuity of services after discharge, availability of community mental health and outpatient services, or family supports and social support systems.[18] This category of indicators also overlaps with *4. The Social Determinants of Health* category, given that service access is also affected by other social factors that are linked to, but separate from the healthcare system, such as poverty (low income and unemployment), and homelessness, which are significant factors in rates of hospital admission for people with MHASU needs.[19]

The service access indicators available in this report include:

3.1	**Percentage of people who indicated a need for mental health care but their needs were either unmet or partially met (aged 12 and older)** (2023)	Indicates the percentage of people aged 12 or older who reported a perceived need for mental health care (examples: information, medication, and counselling) in the last 12 months but that their needs were either not met or only partially met. Lower rates are better.
3.2	**Percentage of youth aged 12-24 with early MHASU needs who accessed Community Mental Health (CMH) services in the last 6 months** (2022)	Measures the proportion of children and youth aged 12-24 with early mental health and substance use health needs who were able to access care within six months of being surveyed (2022). Early mental health and substance use needs are defined as a new or pre-existing functional impairment or a perceived need for care reported by children and youth in the last six months. Children and youth who reported severe impairment with an onset prior to the past six months were excluded.[20] This measure indicates whether children and youth in Canada are accessing early intervention services when they have early mental health and substance use needs. Early intervention can help reduce symptoms and the severity of the issues and may help to avoid or delay progression to a diagnosed disorder. Higher rates are better.

	Indicator	Description
3.3	**Supply of psychiatrists per 100,000 population** (2019)	Indicates the number of psychiatrists per 100,000 within a province or territory. Higher rates may suggest greater access to psychiatrists.
3.4	**Supply of MHASU health care providers per 100,000 population** (2021)	Indicates the number of MHASU health care providers per 100,000. “Providers” here refers to social workers, family physicians, occupational therapists, licensed practical nurses, nurse practitioners, registered nurses, registered psychiatric nurses (RPNs), psychologists, psychiatrists, paramedics, psychotherapists, and counselling therapists. Due to the wide range of practitioners included for this indicator in Canada, it is difficult to compare these data internationally, as the criteria elsewhere restrict practitioners to those working specifically in the mental health sector (i.e. psychiatrists, mental health nurses, social workers, psychologists - see the World Health Organization’s Global Health Observatory Data Repository for reference.) The Canadian data also include family physicians and nurse practitioners. A higher number is more desirable.
3.5	**30-day hospital readmission rates for MHASU** (2022-2023)	Measures the percentage of people who were readmitted to hospital (inpatient hospitalizations in psychiatric and general hospitals) for MHASU, regardless of diagnoses, within 30 days of discharge after an initial admission for MHASU (also called an “index episode”). Lower rates are better.

4. SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the economic and social conditions that affect a person's health status. Research shows that only 20-25% of health rests on clinical (medical) health care delivered in hospitals, doctors' offices, or in other healthcare settings, and that the remainder of our health depends on other factors such as social and economic conditions (50%), biology and genetics (15%), and our physical environments (10%).[21] That is why it is so critical to collect data and report on the social determinants of health, which include the rates of poverty and low income, homelessness, education levels, employment and data about family circumstances and environmental conditions in the general population and also specifically for people with MHASU needs. Collecting, measuring, and reporting on these social determinants present an opportunity for governments to make better and more informed policy decisions to address the social inequalities that shape MHASU health.[22]

This report includes the following social determinant of health indicators:

4.1	**Percentage of people reporting poor-to-fair mental health in core housing need** (2021)	Indicates % of people reporting poor-to-fair mental health who have a core housing need. Those in core housing live in an unsuitable, inadequate or unaffordable dwelling and cannot afford alternative housing in their community.[23] The lower the rate, the better.
4.2	**Poverty rate, based on Market Basket Measure (MBM)** (2020)	Indicates the % of people in Canada who live in poverty using the Market Basket Measure (MBM). The MBM goes beyond income alone and accounts for the cost of a "basket" of items such as food, clothing, housing and transportation for a family of four, adjusting for the region where they live in Canada. A family with a disposable income below the MBM threshold is deemed to be living in poverty. This indicator is for the general population (not specific to people with MHASU health concerns). Lower rates are better.
4.3	**Employment rate for individuals with mental health disabilities (ages 25-64)** (2017)	Percentage of individuals with mental health-related disabilities between the ages of 25 to 64 who are employed. Higher rates suggest greater workforce participation of individuals with mental health-related disabilities.

5. STIGMA, DISCRIMINATION AND MISTREATMENT

People experiencing mental health or substance use difficulties are at higher risk of experiencing discrimination, stigma and human rights violations. These experiences are dehumanizing in and of themselves and present barriers to full inclusion and participation in society and can produce social disadvantage, including disadvantages in one's personal relationships, education and work. They also contribute to mental distress and can worsen the symptoms of illness.[24] Reducing and eliminating incidences of stigma and discrimination lead to better access to health care, better health outcomes, higher feelings of self-worth, and greater social inclusion. Measuring stigma and discrimination is thus important because this data can provide a barometer for how well a society is doing when it comes to eliminating barriers for people with MHASU concerns and promoting full inclusion and participation.

The indicators selected for this section include:

	Indicator	Description
5.1	**Percentage of people reporting poor-to-fair mental health who experience discrimination and victimization** (2019)	Indicates the percentage of people aged 15 years or older who self-report poor-to-fair mental health and experienced victimization. Lower rates are better.
5.2	**Percentage of people reporting poor-to-fair mental health who report feeling a stronger sense of belonging to community** (2020)	The percentage of people aged 15 years or older who report poor-to-fair mental health and who describe their sense of belonging to their local community as *somewhat strong* or *very strong*. A higher percentage is more desirable.
5.3	**Rate of police-reported drug offences** (2022)	Indicates the rate of police-reported offences for all drugs that may or may not lead to a charge and prosecution. This indicator provides some insight into the rate at which people who use drugs are criminalized. This is important given that criminalization impacts people's access to housing, employment, and healthcare services. While "offence" includes possession, trafficking, production and importation/exportation, past years' data on this indicator show that possession accounts for more than half of the offences reported in a given year, depending on the type of drug involved. This rate excludes cannabis offences. Lower rates are better.

IN FOCUS >

Mental Health in CANADA

Population: 41,012,563

Canada emerged from the COVID-19 pandemic with a new appreciation for positive mental health. As inflation rates and the cost of living soared amidst the many pandemic stressors, our mental health suffered, too; people in Canada experienced an increase in the rates of poor mental health, a rise in deaths due to the toxic drug supply and increased hospitalizations due to alcohol. The concerning rates of suicide, especially for Canada's northern First Nations and Inuit peoples, have prompted some communities to declare public health emergencies—a sign that Canada is failing to meet its human rights obligations to Indigenous Peoples and its commitments to advancing the calls to action of the Truth and Reconciliation Commission. Pandemic-era government income supplements substantially lowered the poverty rate, but that rate is likely to rise again as those benefits have ended. Access to mental health, addictions and substance use health (MHASU) services is uneven across the country and the demand for services outstrips availability. Evidence suggests that we need better and consistent access to MHASU services as we navigate the aftershocks of the pandemic.

IN FOCUS: CANADA

Indicator		Indicator Category	CAN
1.1a	Mental health, addictions, and substance use (MHASU) Healthcare Investments	Policy	6.3%*
1.1b	Bilateral Health Spending for MHASU	Policy	31%
1.2	MHASU Strategy	Policy	Out of date
1.3	Decriminalization policy	Policy	Low support
1.4	Harm reduction policy	Policy	High support
1.5	Mental Health Acts	Policy	–
2.1	Perceived mental health – poor/fair	Population Mental Health (MH)	26.1%
2.2a	Prevalence of mood/anxiety disorders (12-month)	Population MH	10.6%
2.2b	Prevalence of substance use disorders (lifetime)	Population MH	20.7%
2.3	Rate of death by suicide	Population MH	10.9
2.4	Rate of hospitalization for self-harm	Population MH	64.9
2.5	Rate of apparent opioid toxicity deaths	Population MH	20.8
2.6	Rate of hospitalizations caused entirely by alcohol	Population MH	262
3.1	Percentage of population needing mental health care but needs are unmet or partially met	Service access	7.8%
3.2	Percentage of youth with early MHASU service needs who accessed Community Mental Health services	Service access	61%
3.3	Number of psychiatrists per 100,000 population	Service access	13.1
3.4	Supply of MHASU healthcare providers	Service access	1,721.4
3.5	30-day hospital readmission rates for MHASU concerns	Service access	13.4%
4.1	Percentage of population reporting poor-to-fair mental health in core housing need	Social Determinants of Health (SDOH)	15.8%
4.2	Poverty rate	SDOH	8.1%
4.3	Employment rate for individuals with mental health disabilities (ages 25-64)	SDOH	46.1%
5.1	Percentage of those with poor-to-fair mental health who experienced discrimination and victimization	Stigma and discrim	9.1%
5.2	Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community	Stigma and discrim	54.4%
5.3	Reported rate of drug-related offences	Stigma and discrim	162

*National average

Note: Values in the table above that do not have a percentage indicate a rate per 100,000 population

IN FOCUS: CANADA

Using national-level data disaggregated by province and territory, this profile provides a snapshot of the well-being of our population and examines data on mental healthcare service use and the need for social supports. It also assesses the strength of federal policies and governance for supporting a robust mental health, addictions, and substance use (MHASU) healthcare system.

As noted in the methodology section, we selected 24 indicators that speak to population mental health and access to services and supports. We sourced data that were available both nationally and for the provinces and territories that we present in this report as stand-alone profiles. The indicators for this "Canada" profile are listed in the table above. All of the MHASU Policy Indicators (Indicators 1.1-1.5) are comprised of data that are based on federal governance and policy, whereas the other indicators represent national averages. To see a full and detailed description of our process for data collection and analysis, please see the Methodology section.

POLICY

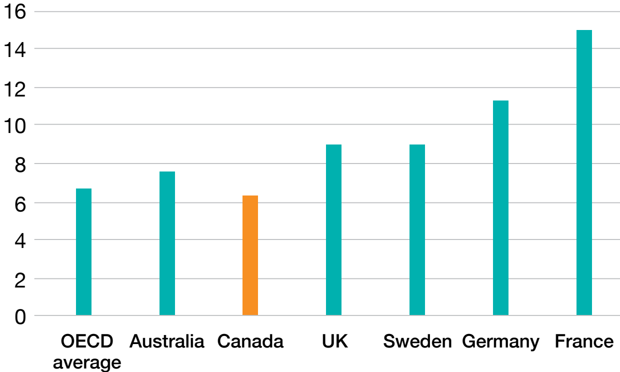
One key takeaway from the global COVID-19 pandemic was the importance of mental health. In the thick of the pandemic, and perhaps for the first time in Canadian political history, mental health was at the forefront of Canadian healthcare policy discussions: in 2020, the Government of Canada introduced Wellness Together, a free online platform to support mental health during the pandemic, and mental health was a key issue in the 2021 federal election. Despite this attention, shortcomings persist in Canadian MHASU healthcare policy and funding.

Funding

Canada is lagging behind when it comes to MHASU spending. According to OECD estimates, mental health spending varies substantially across peer jurisdictions: as a percentage of the total healthcare spending, it is as low as 3.4% in Italy and as high as 15% in France. At 6.3%, which represents the average spending across Canadian provinces and territories, Canada is close to the OECD average of 6.7%, but is surpassed by France (15%), the UK (9%), Sweden (9%) and Germany (11.3%) (**Chart 1**).

Chart 1

Spending on mental health as a % of overall government health spending, by country



Sources: OECD, A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health.

The King's Fund, Mental Health 360: Funding and Costs.

Dedicated federal spending for mental health is far lower, however. In the lead up to the 2021 election, the Liberal Party of Canada, which went on to form a minority government, campaigned on

a promise to introduce the Canada Mental Health Transfer, a permanent transfer for mental health of approximately $2.5 billion annually. The promised Transfer was never delivered, and the government announced instead that it would establish Bilateral Health funding agreements with the provinces and territories. These Bilateral deals, known as the *Working Together Agreements*, commit $25 billion over 10 years to support four shared health priorities, one of which is mental health, addictions and substance use health care. A total of $2.7 billion for MHASU was negotiated with the provinces and territories for 2023-2026–funding that also includes remaining funds from the 2017 Shared Health Priorities Bilateral Agreements. For the 2024-2025 fiscal year, that means $903 million in spending for MHASU. When we consider this amount in relation to the total healthcare spending in the Canada Health Transfers, which is $52.1 billion in 2024-2025, the dedicated MHASU funds in the *Working Together Agreement* for that same year is only a drop in the bucket.

FALLING SHORT

Only half the recommended amount of funding goes to mental health.

Strategy

Strong governance in health care isn't only about funding. It also means having a strong MHASU strategy with a robust accountability framework. The Government of Canada established the Mental Health Commission of Canada (MHCC) with a mandate to produce the first mental health strategy for Canada, and in 2012, MHCC released *Changing Directions, Changing Lives*, with six strategic directions and 109 recommendations for action.[25] However, no subsequent strategies or updates have been released despite the significant changes that have occurred in the MHASU landscape since 2012.[26] Canada needs to renew and strengthen its mental health strategy with an equally strong accountability framework, just as it did for the *Canadian Drugs and Substances Strategy*, updated in 2023,[27] to ensure national progress in support of the health and well-being of people in Canada.

Canada remains one of only two G7 countries without a national suicide prevention strategy. In 2016, the federal government launched the National Suicide Prevention Framework and only in May 2024 did it release an Action Plan.[28] The Action Plan followed the introduction of 9-8-8, a new national crisis helpline available 24/7 to provide support to people in crisis. The Pillars of Action identified in the Action Plan align with the foundations of suicide prevention from the World Health Organization (WHO) and include data and monitoring; research and evaluation; supports and services; and governance. A nationally funded suicide prevention strategy is still required: one that outlines a plan to implement a coordinated, cross-societal approach to close the gaps and harmonize efforts.[29]

WORK IN PROGRESS

The federal government introduced 9-8-8 and has developed a National Suicide Prevention Framework and Action Plan, but the plan hasn't been funded.

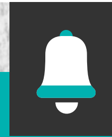
IN FOCUS: CANADA

Policy response to the toxic drug crisis

Over the last eight years, the Government of Canada has made significant positive changes to federal drug policy in response to the mounting drug toxicity crisis. It introduced a renewed *Drugs and Substances Strategy* in 2016 that restored harm reduction as a pillar and created a policy framework rooted in a public health approach, setting the stage for new legislative changes and program investments that were carried over and further developed in the most current strategy (2023).

In 2017, the Government of Canada introduced Bill C-37, an *Act to amend the Controlled Drugs and Substances* (CDSA), to make it easier to establish supervised consumption sites (SCS) and to allow exemptions from the Act to permit services like drug checking.[30] That same year, it also introduced the *Good Samaritan Drug Overdose Act*, and moved Naloxone, an antidote to opioid poisonings, from a Schedule I to Schedule II Drug, making it more widely available. It created a national surveillance system which introduced quarterly reporting for the rates of deaths, hospitalizations and calls to Emergency Medical Services (EMS) due to opioid toxicity. In 2019, the Government of Canada also introduced the Substance Use and Addictions Program (SUAP), which has funded projects ranging from substance use education and prevention; innovative pilot drug checking and safer supply programs; wrap around addictions supports; and culturally relevant and safe programs. Then, in August 2020, the Government sought to address the criminalization of people who use unregulated drugs by issuing a new guideline only to prosecute only serious possession offences, akin to decriminalization policy, and allowing provinces and territories to apply for exemptions to the CDSA to remove criminal penalties for simple possession of unregulated drugs.[31]

Despite these welcome policy changes and investments, critical gaps remain.



NOTEWORTHY

An updated strategy and legislative changes to drug policy to facilitate harm reduction

Still needed are sustained investments in harm reduction and in the continuum of supports for substance use health and addiction treatment. As we show in the profiles in this report, harm reduction programs are vulnerable to shifting policy priorities among provincial and territorial governments, and the changing landscape of the toxic drug supply can make it difficult for the provinces and territories to adapt to changing population needs and keep apace with new harm reduction innovations and technologies. This results in major differences among Canada's provinces and territories when it comes to access to substance use health supports. SUAP is slated to end in March 2028, as Budget 2024 did not commit to renewing the program. Neighbourhood resistance to the establishment of new supervised consumption sites (NIMBYism)[32] continues to be a barrier to establishing these services in communities across Canada and to the creation and preservation of harm reduction services. In many places across Canada, there is also a shortage of organizations offering drug checking and supervised inhalation services and there is growing resistance to safer supply programs. The future of many harm reduction programs is at risk. This is a critical concern, given that many of these interventions have been saving lives.[33]

In addition, the criminalization of people who use drugs continues to be a problem even though the Government of Canada issued guidance to prosecute people for simple possession only in "the most serious cases."[34] Recent data from 2021 is showing that incidences of police reported crime for drug offences is trending downwards, with a 9% reduction in Canada.[35] Despite the drop in this rate, people who use drugs continue to be subjected to drug

seizures, arrest and imprisonment in the absence of *de jure* (legally recognized) decriminalization legislation. The Government of Canada continues to reiterate that it will not amend federal law to decriminalize simple possession, but that it will continue to support provinces and territories that wish to apply for an exemption.[36] However, this position may be shifting: the Government of Canada recently approved the B.C. government's request to *retract* its decriminalization pilot in response to concerns over the use of drugs in public spaces.[37] The City of Toronto's application for an exemption was also recently rejected.[38]

POPULATION MENTAL HEALTH

When we look at the population mental health indicators for Canada—population mental health being the state of psychological and emotional well-being at the population level among different groups of people[39]—two concerns come to light: First, that we have not moved the needle substantially on addressing the factors underlying poor mental health; and secondly, that the rates of harm due to substance use have been rising, particularly since COVID-19.

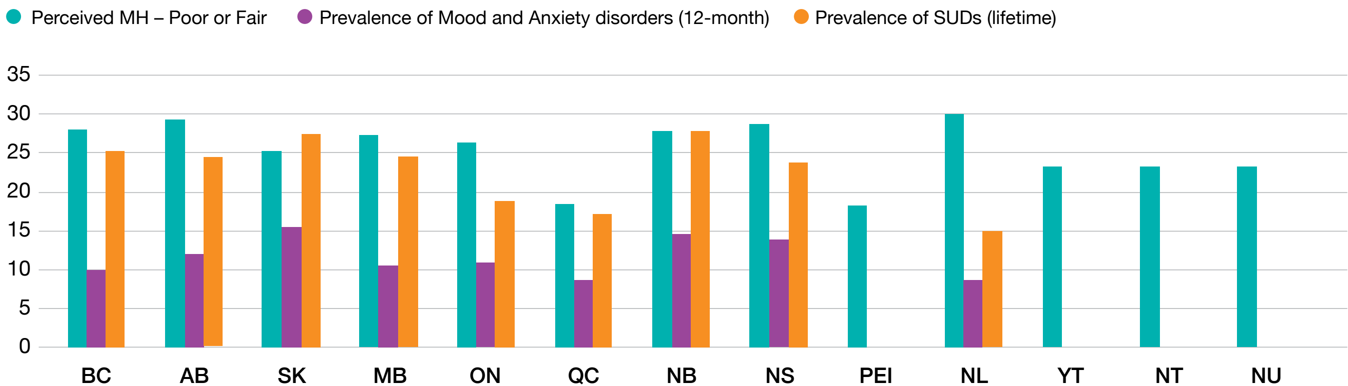
HIGH ALERT

More than a quarter of Canadians reported their mental health was "poor" or "fair." This is much higher for Indigenous peoples (38%).

In 2021, 26.1% of Canadians reported that they had "poor" or "fair" mental health. This is a dramatic increase from the pre-pandemic 2019 rate, which was 8.9%.[40] Among the provinces and territories, self-ratings of "poor" or "fair" mental health status are highest in Newfoundland and Labrador (30%), Alberta (29.3%), and Nova Scotia (28.8%). The lowest rates were recorded in Québec (18.4%) and PEI (18.3%), meaning the people in these provinces report higher rates of good mental health. Notably, people in the territories report the third highest rates of good mental health even though they report lower performance among other population mental indicators (see discussion below). Nationally, however, mental health is rated considerably lower among Indigenous peoples than among non-Indigenous peoples. In 2021, 38% of Indigenous peoples reported their mental health as "poor" or "fair."[41]

Chart 2

Perceived mental health (2021) and Prevalence rates of illness (2022), % of the population, by province and territory



Sources: Statistics Canada. (2021). Canadians' Mental Health Public Use Microdata File.

Statistics Canada. (2022). Mental Health and Access to Care Survey, 2022.

IN FOCUS: CANADA

It is important to measure rates of death by suicide. Not only do these numbers represent a tragic loss of life, but deaths due to suicide are also wholly preventable. The rates of death by suicide can provide insight into the state of mental health and mental illnesses in a population and the progress achieved across Canada in suicide prevention, which includes improving access to MHASU services.

Among the provinces and territories, the Prairie Region has a higher rate of suicide per 100,000 people; Alberta (14.3), Saskatchewan (17.6) and Manitoba (13.9), compared to the average in Canada (10.9). However, the highest rate reported across the country is in Nunavut, at a rate of 72.2 per 100,000 people.

Chart 3

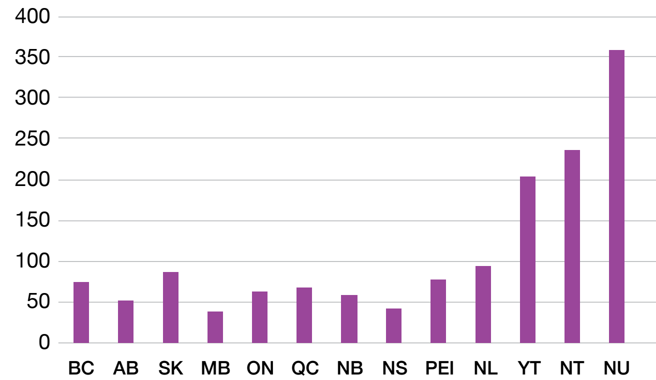
Rates of suicide per 100,000 population, by province and territory, 2020

Source: Government of Canada. (2023). Suicide, self-harm, and suicide-related behaviours in Canada (2020): Suicide mortality

The reported rates of hospitalization due to self-harm in Canada vary considerably within regions (**Chart 4**), with the exception of the territories, which report disproportionately high rates of self-harm: Nunavut (360.3/100,000), Northwest Territories (237.2) and Yukon (204.8). After the territories, higher rates are also reported in Saskatchewan, Newfoundland and Labrador, and PEI.

Chart 4

Rates of self-harm per 100,000 population, by province and territory, 2020



Source: Government of Canada. (2023). Suicide, self-harm, and suicide-related behaviours in Canada: Self-harm.

Equally concerning are the harms due to alcohol and the unregulated toxic drug supply which continue to rise. In 2023, Canada recorded 20.8 deaths due to opioid poisoning per 100,000 people, an increase from the rate recorded in 2022, which was 19.6 deaths per 100,000.[42] That's 8,049 lives lost to opioid poisonings in 2023 alone.

HIGH ALERT

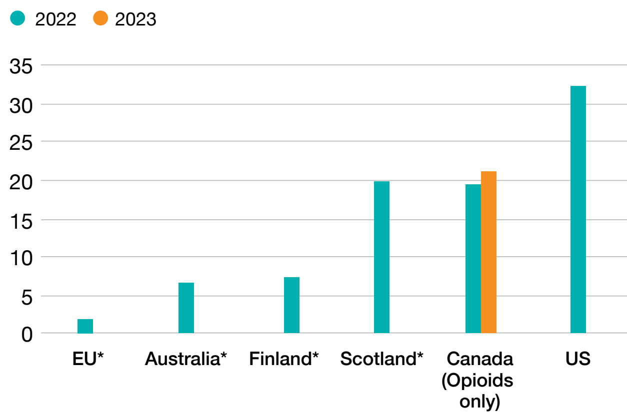
Second-highest opioid death rate in the world, after the US.

IN FOCUS: CANADA

After the United States, Canada has the second highest rate of deaths in the world due to opioid toxicity (**Chart 5**).[43] Before the pandemic, the rates of harm due to alcohol and opioids had a modest decline. However, with COVID-19, there was a notable surge in harms (**Chart 6**), an increase that has been attributed to several factors, including the disruption to the supply chain of unregulated drugs and the unintended consequences of public health measures that were put in place to protect the public from COVID-19, such as service suspensions and physical distancing.[44]

Chart 5

Rate of drug-related deaths* per 100,000 population, by country



Sources: Federal, provincial, and territorial Special Advisory Committee on the Epidemic of Opioid Overdoses. Opioid- and Stimulant-related Harms in Canada. Ottawa: Public Health Agency of Canada; March 2024.

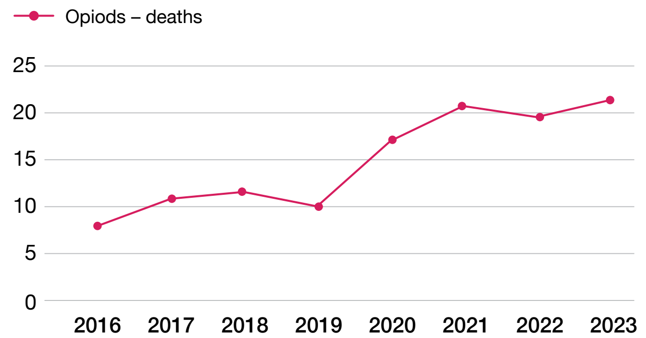
EMCDDA, European Drug report, 2022.

https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/data-by-region/drug-induced-deaths

*EU, Scotland, Australia and Finland's data include all deaths where drugs were the underlying cause. The indicator "drug-induced deaths" thus includes opioids, stimulants and other drugs. The rate for Canada here should be considered underreported when compared to these countries given that Canada's rate only represents opioid-related deaths.

Chart 6

Trends: Rate of total apparent opioid toxicity deaths in Canada, 2016-2023, per 100,000 population



Source: https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/graphs.html?ind=9&unit=0

In addition, the rates of alcohol consumption also increased during the pandemic, with 30% of the population reporting increased drinking (**Chart 7**).[45] However, while the rates of hospitalization due to alcohol are in decline, the harms due to opioids continue to rise in the wake of the pandemic although the rate of substance use disorders (SUDs) has not changed substantially among the Canadian population.

In fact, the data on the rate of SUDs for 2022 indicate that the lifetime prevalence rate dipped slightly between 2015 and 2022, from 21.6% to 20.7%.

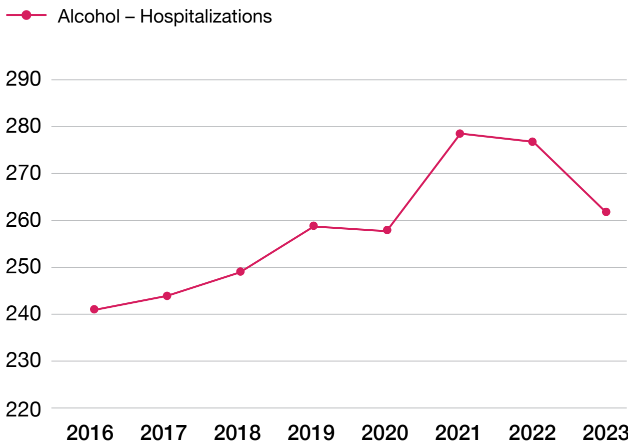
FALLING SHORT

Stale-dated mental health strategy

IN FOCUS: CANADA

Chart 7

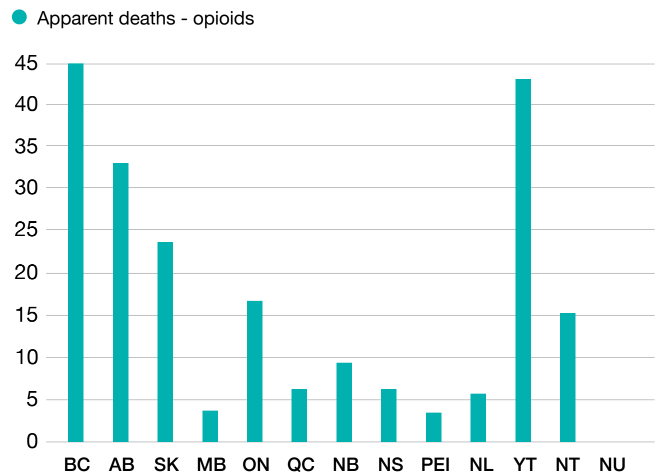
Trends: Hospitalizations caused entirely by alcohol in Canada from 2016-2023, rate per 100,000



There is a noticeable pattern in the rates of harm due to alcohol and opioids among Canada's regions, with the highest rates reported in Canada's westernmost provinces and the territories for both indicators (**Charts 8 and 9**). British Columbia continues to report the highest rate of apparent opioid toxicity deaths, at 46.6 per 100,000, followed by Alberta (39.4), Yukon (37.8) and Saskatchewan (24). The rates of hospitalization due entirely to alcohol are disproportionately high in the Northwest Territories (1,412), Yukon (948), and Nunavut (757), followed by British Columbia (385), Saskatchewan (375) and Alberta (333). Although the Atlantic provinces have the lowest rates of apparent opioid toxicity deaths, the harms caused by opioids and especially stimulants are rising concerns, with the rates having more than doubled from pre-pandemic rates in some of these provinces.[46] In the western and prairie provinces which report higher rates of harms due to alcohol and opioids, the rates of substance use disorders are also higher, ranging between 24.4% to 27.5%, as compared to the Canadian average of 20.7%. There are, however, exceptions. While New Brunswick reports lower rates of harm for both alcohol and opioids, the prevalence rate of SUDs is the highest in the country at 27.9%.

Chart 8

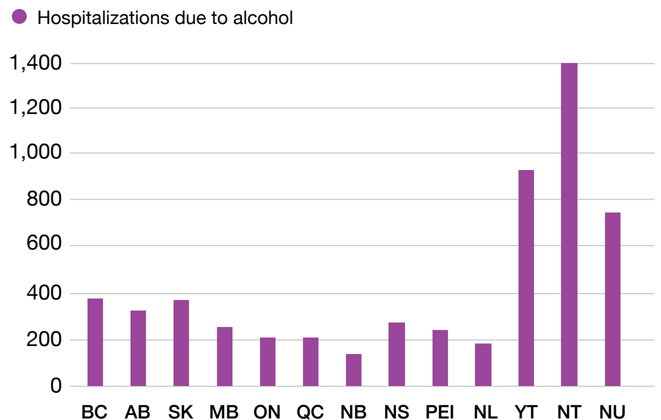
Apparent deaths due to opioid toxicity, rate per 100,000 by province and territory (2023)



Source: Government of Canada. (2024). Opioid- and Stimulant-related Harms in Canada (2023)

Chart 9

Hospitalizations due entirely to alcohol, rate per 100,000 by province and territory (2022-2023)



Source: Canadian Institute for Health Information. (2024)

SERVICE ACCESS

The indicator data on MHASU service access in this report showcase that access to services within our country is very uneven.

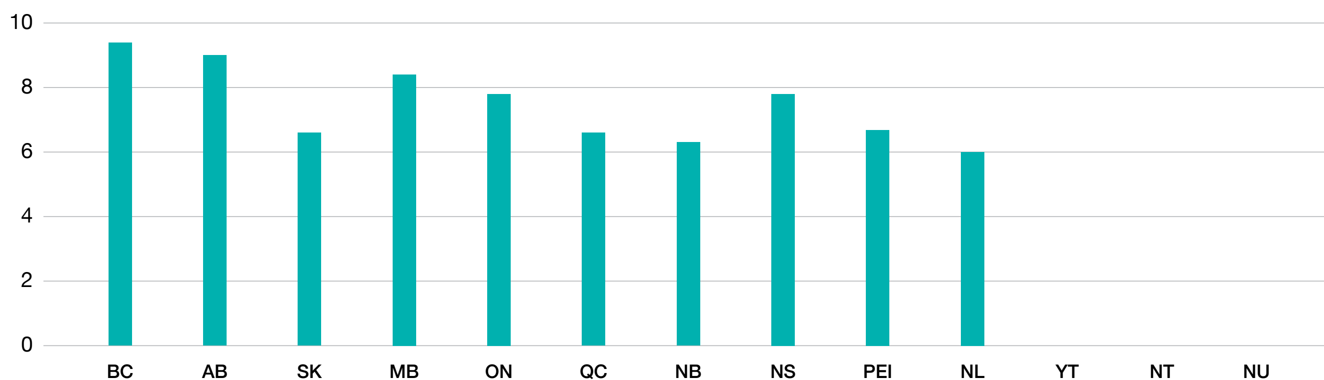
As already noted, we are cautious about making comparisons between Canada and international jurisdictions because of differences among our healthcare systems and standards for performance measurement. This is particularly true for service access data: some studies are at a regional rather than national level or may be based in data collected from a hospital or community mental health clinic. Recognizing these limitations, international data on unmet needs among those with MHASU problems vary from 3.1% to 15.5%.[47] The rate reported for Canada is 7.8%.[48] When it comes to the distribution of psychiatrists, we are below European countries. In Canada the rate is 13.1 per 100,000 people and the OECD average is 16.8 per 100,000.[49]

When we examine the distribution of the data for each indicator *within* Canada, the inequities are evident among the provinces and territories, and regional trends emerge.

There are regional disparities in reported unmet needs among Canadian provinces (**Chart 10**). Among the provinces with the highest percentage reporting unmet or partially met mental health needs, British Columbia (9.4%) takes the lead, followed by Alberta (9%), Ontario (7.8%) and Nova Scotia (7.8%). The provinces with the lowest levels include Newfoundland and Labrador (6%), New Brunswick (6.3%), Saskatchewan (6.6%), Quebec (6.6%) and PEI (6.7%).

Chart 10

% Who needed MH care but their needs were either unmet or partially met, by province and territory (2023)

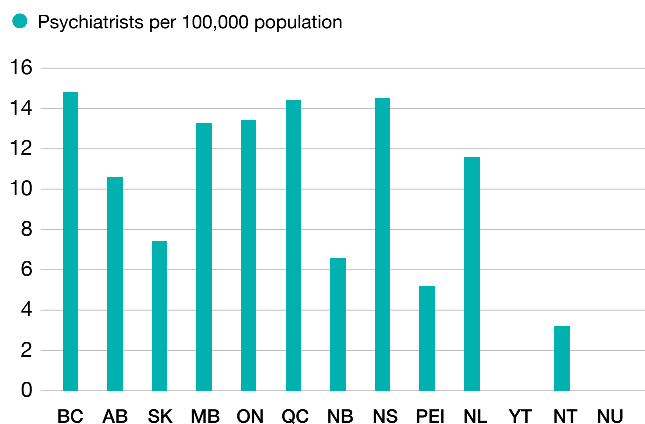


Source: Statistics Canada. (2023). Canadian Community Health Survey – Annual Component; Mental health characteristics: Perceived need for mental health care.

The distribution of the MHASU workforce is also uneven across Canada. Notably, there are far fewer psychiatrists practicing in Canada's rural and northern/circumpolar areas (**Chart 11**). British Columbia (14.8 per 100,000 people) has the highest number of psychiatrists per 100,000 population, followed by Nova Scotia (14.5) and Québec (14.4), while the lowest number is found in the Atlantic provinces and the Northwest Territories (3.2), Prince Edward Island (5.2) and New Brunswick (6.6). When considering the supply of the entire MHASU workforce, the more rural Atlantic provinces and Yukon perform better than the central and western provinces (**Chart 12**). The rates per 100,000 were highest for Newfoundland (2,203.6), Nova Scotia (2,224.9), New Brunswick (2,067.5), PEI (1,957.5) and Yukon (2,205.2), while British Columbia (1,446.8), Ontario (1,609.9), and Quebec (1,817.0) report lower rates. We note that for the MHASU workforce, the Northwest Territories and Nunavut report the lowest rates in the country, at 1,110.8 and 676.8 per 100,000, respectively.

Chart 11

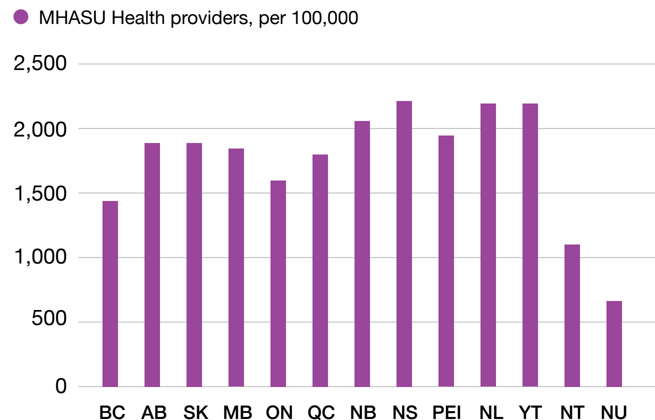
Distribution of psychiatrists per 100,000 population, by province and territory (2019)



Source: Canadian Medical Association, Psychiatry Profile. (2019). CMA Physician Workforce Survey

Chart 12

Supply of MHASU health providers in Canada per 100,000 population, by province and territory (2021)



Source: Canadian Institute for Health Information. (2021). A profile of selected mental health and substance use health care providers in Canada, 2021.

The rates of 30-day hospital readmission were lower for the prairie provinces and higher for western Canada, the Territories and central Canada (**Chart 13**). The highest 30-day hospital readmission rates were in the Northwest Territories (17.6%), British Columbia (15.3%), Yukon (15.1%), followed by Ontario (13.7%) and Québec (13.0%). The lowest rate of readmission was noted in Nova Scotia (10.3%), and the prairies all had similar rates that fell below the national average, together averaging around 11.1% compared to the 13.4% average for Canada.

Chart 13

30-day hospital readmission rates for MHASU concerns, by province and territory (2022-2023)

Source: Canadian Institute for Health Information. (2023). 30-Day Readmission for Mental Health and Substance Use.

THE SOCIAL DETERMINANTS OF HEALTH

Housing, income and employment are all important social determinants of health. Yet, people with mental health disabilities and/or mental health difficulties in Canada are disproportionately living in poverty. Faced with fewer opportunities for adequate employment, many live on income supports and are not housed adequately. Disability income supports are often insufficient, in some instances falling 30% below provincial and territorial low-income measures.[50]

The higher rates of poor mental health reported among those with low income demonstrate the strong association between income and mental health: in Canada, people in the lowest income group report having anxiety at a rate 2.4 times higher than those in the highest income group.[51]

Canada needs to improve in this category to help keep people with mental health, addictions, and substance use health concerns out of poverty and adequately housed.

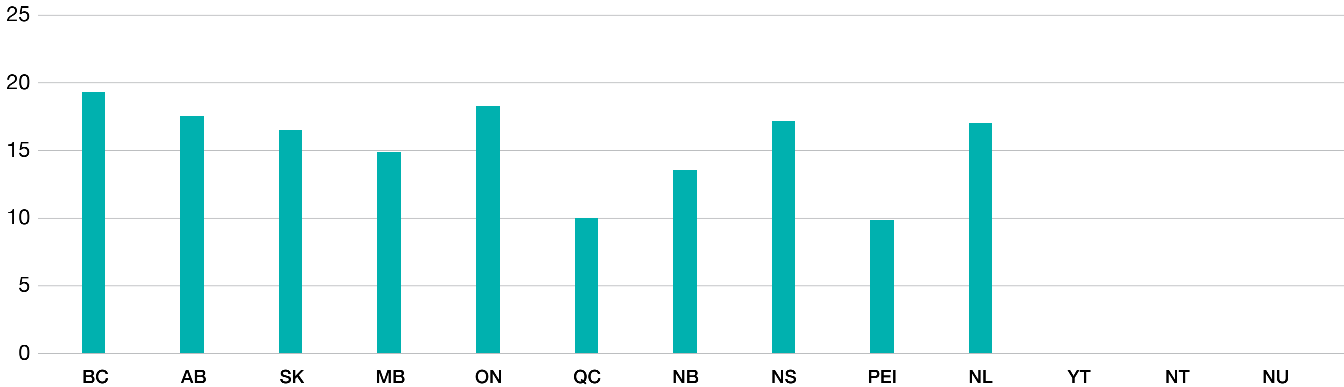
Housing

Housing is a basic human right and a requirement for good health. The right to housing is protected under international law in The United Nations' Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights, and as a signatory, Canada has endorsed such rights guaranteeing "an adequate standard of living… including adequate food, clothing and housing." The Ottawa Charter for Health Promotion identifies shelter as a basic prerequisite for health.[52]

Despite these commitments, Canadians with poorer mental health status are more likely (15.8%) to live in inadequate housing than those reporting good mental health (10.1%).[53] The national average for core housing need in Canada is 15.8% for people with lower self-rated mental health, and the rates are highest in British Columbia (19.1%), Ontario (18.1%), and Alberta (17.4%), provinces which experience stark housing shortages and affordability problems. Concerningly, the rate of homelessness increased over the course of the pandemic, and the Federal Housing Advocate estimates that 20-25% of Canada's unhoused population lives in tent encampments.[54] Canada has fallen behind other OECD countries, with only 5.4% of the total housing units dedicated to non-market-based community housing stock.[55] Community housing is critically important for people with mental illnesses, addictions and substance use health concerns, as models such as supportive housing are deeply affordable and make housing available. Housing is also an equity concern in Canada, as Indigenous peoples are more likely than the non-Indigenous population to live in housing needing major repairs (16.4% vs. 5.7%) or that is inadequate in size for the number of occupants (17.1% vs. 9.4%).[56]

Chart 14

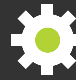
% of those with poor-to-fair mental health in core housing need, by province and territory (2021)



Source: Statistics Canada. (2024). Canadian Housing Survey: Public Use Microdata File.

IN FOCUS: CANADA

The Government of Canada has been working to address homelessness and the housing crisis through several measures. In 2017, it introduced *A Place to Call Home*, a ten-year National Housing Strategy. Initially funded at $40 billion with programs and policies designed to protect, strengthen, and grow Canada's community housing sector, the strategy has since grown to over $82 billion and includes market-based housing programs. It also introduced *Reaching Home: Canada's Homelessness Strategy* in 2019, which supports the goals of the *National Housing Strategy* to enhance access to affordable housing and reduce homelessness nationally by 50% by 2028.[57]



WORK IN PROGRESS

Homelessness, plus unaffordable and inadequate housing are significant problems. A plan and strategy aim to cut homelessness in half by 2028.

Poverty and Employment

Poverty is still very much a concern in Canada. While the poverty rate in 2020 was lower than it was in previous years—declining from 14.5% in 2015, to 10.1% in 2019 and 8.1% in 2020—this dip was driven by temporary pandemic benefits, including government transfers and the Canada Emergency Response Benefit (CERB), which have since ended. During this temporary dip, poverty declined for children by half the levels that were reported in 2015, and it fell from 23.8% to 11.8% for Indigenous peoples, which is lower than the 2015 rate but still well above the Canadian average.[58] However, the 2023 rate of poverty is predicted to return to the higher pre-pandemic levels.[59]

NOTEWORTHY

Financial benefits during the pandemic significantly lowered the poverty rate.

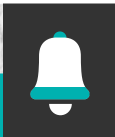
Canada needs to address low income supports and the rates of employment for people with mental health-related disabilities. The rate of employment for people with mental health disabilities is only 46.1% (**Chart 15**). Canada is also among one of the lowest spenders on disability supports in OECD countries—only 0.8% of our GDP goes to disability income supports, compared to 4.5% for Norway and Denmark, the highest spenders.[60]

Chart 15

Employment rate(%) for people with mental health disabilities, by province and territory (2020)

Source: Statistics Canada. (2024). Labour force status for persons with disabilities aged 25 to 64 years, by disability type (grouped).

The Government of Canada introduced *Opportunity for All: Canada's First Poverty Reduction Strategy* in 2017, with a commitment to reduce poverty by 50% from 2015 levels by 2030.[61] In 2023, it also announced its plans to create the Canada Disability Benefit, which was intended to reduce poverty among people with disabilities. However, disability rights groups have voiced concerns that the benefit will not be accessible to the people who need it the most and that the funds will be insufficient for reducing poverty, as the benefit will top out at $2,400 annually.[62]



NOTEWORTHY

Commitment to cut poverty in half by 2030.

WORK IN PROGRESS

The new Canada Disability Benefit must ensure that people with disabilities have enough financial support to live adequately.

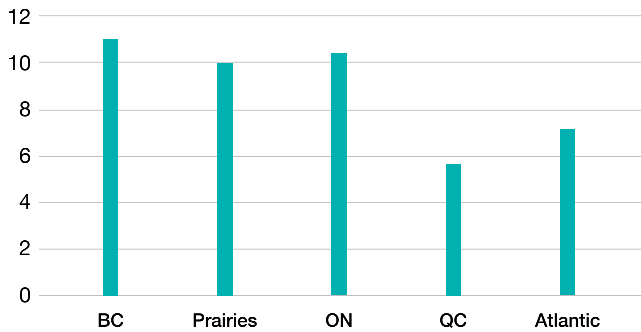
STIGMA AND DISCRIMINATION

Safety, social connection, and freedom from discrimination are critical elements for sustaining good mental health. When it comes to discrimination and victimization of those with mental health problems in Canada and of their sense of belonging to community, there was a smaller range among the provinces and territories. British Columbia and Ontario reported the highest rates of discrimination and victimization for those with poor-to-fair mental health, at rates of 10.9% and 10.3%, compared to the lower rates reported by Québec and the Atlantic provinces at 5.6% and 7.1%, respectively (**Chart 16**). However, despite the higher rate of discrimination, British Columbians with poor-to-fair mental health also reported the highest sense of feeling connected to community, followed by Nova Scotia and New Brunswick (55.9%) and Ontario (55.4%). On both indicators, Alberta and Saskatchewan fared the worst. Alberta and Saskatchewan report a 9.9% rate of discrimination and victimization and a rate of feeling connected to community of only 49.7% and 51.8%, respectively.

IN FOCUS: CANADA

Chart 16

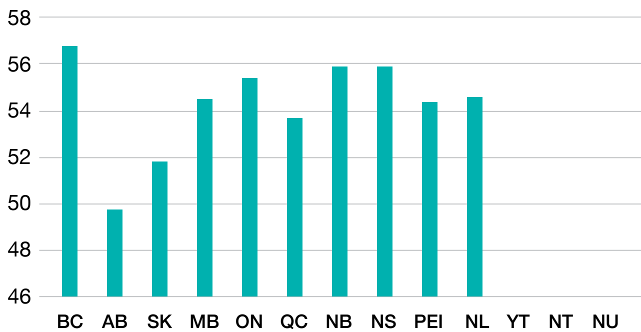
% reporting poor-to-fair mental health who experience discrimination and victimization, by province and territory (2019)



Source: Statistics Canada. (2024). General Social Survey 2019, Canadians' Safety (Victimization): Public Use Microdata File.

Chart 17

% reporting poor-to-fair mental health who feel connected to their community, by province or territory (2021)



Source: Statistics Canada. (2024). General Social Survey, Social Identity (2020): Public Use Microdata File.

Variability stands out among the provinces and territories in the rates of police-reported crime for drug-related offences. A high crime rate attributed to drugs points to the extent to which people who use drugs are criminalized. Drug charges for simple possession can lead not only to imprisonment, but also to adverse health consequences for people who use drugs. Additionally, a criminal record can make it difficult to find employment and housing following a sentence.

Notably, the rate of police-reported crime for drug offences (excluding cannabis) dropped by 12% from 2020 to 2021. At a glance, one would assume this means a decrease in the use of *CDSA* legislation for those found in *possession* of unregulated drugs, given that the federal government issued the (*de facto*) guidance in 2020 instructing that possession be prosecuted in only "the most serious cases." However, for several drugs (excluding cannabis), possession still accounted for more than two-thirds of the offences reported in 2021, even after the federal guidance came into effect. Possession accounts for 72% of all drug offences for methamphetamines, 68% for heroin, and 68% for other opioids. Between 2020-2021, this translates as only a 2% *decrease* for possession for methamphetamines, 4% for heroin, and a 2% *increase* in the rates of possession for other opioids.[63]

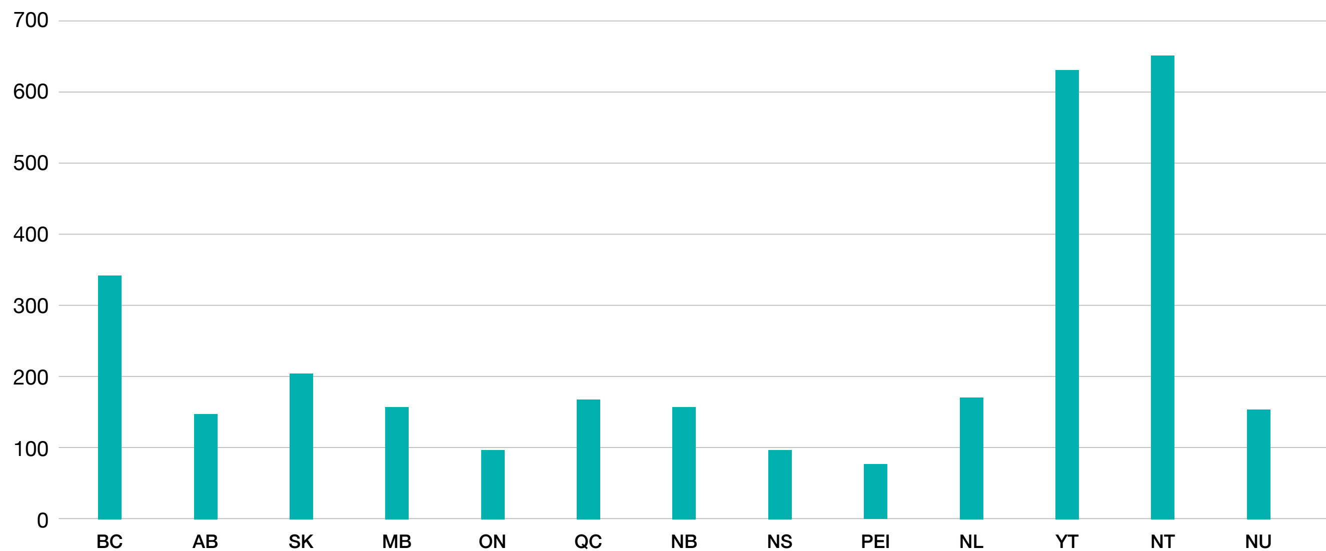
IN FOCUS: CANADA

Across Canada, the rates for all drug offences (including possession, trafficking, production and import/export) also vary: the lowest rates per 100,000 people are reported in PEI (76) and Nova Scotia (96) (both provinces which experience lower rates of death due to unregulated drugs), and the highest rates are reported in the Northwest Territories (653), Yukon (633), and British Columbia (343), the latter two which have been hardest hit by the drug toxicity crisis (**Chart 18**).

With the rollback of British Columbia's decriminalization pilot and the growing public concern regarding decriminalization and the possible threat to public safety, it is unknown whether these changes will result in higher rates of criminalization of people who use drugs.

Chart 18

Rate of police-reported crime for drug offences, by province and territory (2021)



Source: Statistics Canada. (2022). Police-Reported Crime for Select Drug Offences, by Province or Territory, 2021.

IN FOCUS >

Mental Health in BRITISH COLUMBIA

Population: 5,646,467

Rural: 12.7%

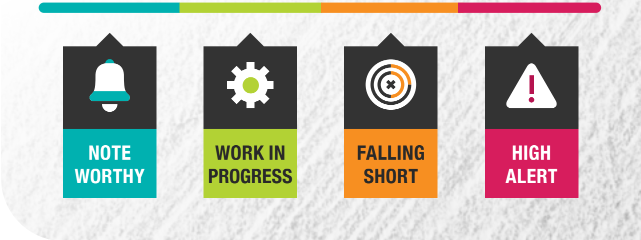
With 32% of all apparent drug-related deaths in Canada occurring in British Columbia, this province is ground zero in the drug toxicity crisis. The high rates of housing insecurity and unaffordability, core housing need and poverty all contribute to these drug-related harms. The BC government's strong commitments to harm reduction and improving population well-being are reflected in its solid mental health strategy. The strategy also targets the social determinants of health, with housing measures and legislation to reduce poverty by 60%. British Columbia reports the highest rates of stigma and discrimination in the country.

BC amended its Mental Health Act in 2022, and its "deemed consent" legislation remains a concern as it allows for involuntary treatment regardless of a person's capacity to consent. The recent rollback of the decriminalization pilot is a step backwards in the hard-won achievements to support the health of people who use drugs and reduce stigma. Despite historic investment for mental health in 2023, the 2024 budget was flat. British Columbians continue to experience greater-than-average barriers to mental health, addictions and substance use health (MHASU) services.

IN FOCUS: BRITISH COLUMBIA

Indicator		Indicator Category	BC	CAN
1.1a	Mental health, addictions, and substance use (MHASU) Healthcare Investments	Policy	Ins.	6.3%
1.1b	Bilateral Health Spending for MHASU	Policy	20.1%	31%
1.2	MHASU Strategy	Policy	Highly comprehensive	Out of date
1.3	Decriminalization policy	Policy	–	Low support
1.4	Harm reduction policy	Policy	High support	High support
1.5	Mental Health Acts	Policy	High concern	–
2.1	Perceived mental health – poor/fair	Population Mental Health (MH)	28.1%	26.1%
2.2a	Prevalence of mood/anxiety disorders (12-month)	Population MH	9.9%	10.6%
2.2b	Prevalence of substance use disorders (lifetime)	Population MH	25.2%	20.7%
2.3	Rate of death by suicide	Population MH	6.9	10.9
2.4	Rate of hospitalization for self-harm	Population MH	75.0	64.9
2.5	Rate of apparent opioid toxicity deaths	Population MH	46.6	20.8
2.6	Rate of hospitalizations caused entirely by alcohol	Population MH	385	262
3.1	Percentage of population needing mental health care but needs are unmet or partially met	Service access	9.4%	7.8%
3.2	Percentage of youth with early MHASU service needs who accessed Community Mental Health services	Service access	68%	61%
3.3	Number of psychiatrists per 100,000 population	Service access	14.8	13.1
3.4	Supply of MHASU healthcare providers	Service access	1,446.8	1,721.4
3.5	30-day hospital readmission rates for MHASU concerns	Service access	15.3%	13.4%
4.1	Percentage of population reporting poor-to-fair mental health in core housing need	Social determinants of health (SDOH)	19.1%	15.8%
4.2	Poverty rate	SDOH	9.8%	8.1%
4.3	Employment rate for individuals with mental health disabilities (ages 25-64)	SDOH	50.3%	46.1%
5.1	Percentage of those with poor-to-fair mental health who experienced discrimination and victimization	Stigma and discrim	10.9%	9.1%
5.2	Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community	Stigma and discrim	56.8%	54.4%
5.3	Reported rate of drug-related offences	Stigma and discrim	343	162

Note: Values in the table above that do not have a percentage indicate a rate per 100,000 population



IN FOCUS: BRITISH COLUMBIA

POLICY

BC's spending on mental health and substance use health (MHASU) care is unknown. BC's budget estimates do not disaggregate MHASU spending from the overall healthcare budget: the only information shared in the budget included the operating costs for the Mental Health and Addictions Ministry Office ($40.5 million) and $215 million over three years in new funding for existing programs, which translates into $70 million for 2024-2025. The *Working Together Agreement* (2023 Bilateral deal) that was recently struck between BC and the Government of Canada will dedicate 20.1% of this healthcare funding to MHASU, which is lower than the Canadian average (31%).

In 2019, the BC government released its 10-year MHASU strategy, *A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia*, setting out priority actions for the first three years. The strategy specifically highlights the importance of mental health promotion, mental illness prevention and early intervention, evidence-based decision making in policy and programs, and investing in the social determinants of health. While the strategy did not outline an accountability framework, the BC government published a progress report in 2023.[64]

Mental Health Act

BC's *Mental Health Act* was amended in 2022 in response to concerns raised by Health Justice, the Ombudsperson and a constitutional court challenge that the legislation was undermining the rights of people with mental illnesses.[65] An investigative report found that the Act was resulting in an overreliance on involuntary services for people with mental illnesses and lacked appropriate procedural safeguards for those detained. The new amendments, passed with Bill 23, established an independent rights advice service for people admitted involuntarily to a psychiatric or treatment facility, a step in the right direction toward safeguarding human rights. Health Justice noted that the new rights service needs to be monitored closely, however, to determine whether it is truly accessible and transparent.[66] Furthermore, "deemed consent" is still part of the Act, and states that anyone with involuntary status is presumed to have agreed to psychiatric treatment, thereby removing patient agency in decision making about their treatment.

Policy Response to the toxic drug crisis

As the number of apparent opioid toxicity deaths continues to soar in BC, the province has been responding with a policy framework to address the harms. BC has been an innovator in creating policies and piloting programs. It was the first province to declare, in 2016, the drug toxicity crisis a public health emergency. The BC government has introduced programs for drug checking, overdose prevention services and safer supply. It has the highest number of supervised consumption/overdose prevention services in the country: a total of 47 sites.

WORK IN PROGRESS

BC's *Mental Health Act* was amended in 2022 to better safeguard human rights, but "deemed consent" is still a problem.

Recently, however, government support for certain harm reduction policies has been waning. The pilot legislation decriminalizing personal possession of unregulated drugs was rolled back recently, not long after the government introduced new legislation restricting public drug use—legislation which the previous Chief Coroner was paused by BC's top court.[67] The Premier, Chief Coroner, and Provincial Health Officer have been openly in disagreement over the merits of safer supply, and the BC government has been increasingly favouring access to treatment beds to address the toxic drug crisis.[68]

Furthermore, BC's auditor general recently released a report critiquing BC's Ministries of Health and Mental Health and Addictions for weaknesses in their overdose prevention and safer supply policies, particularly regarding the barriers to establishing the services and addressing health providers' hesitancy about prescribing drugs.[69] The rising rate of death in the province due to opioid toxicity is also linked to the need for more overdose prevention sites offering safer inhalation services. As of October 2023, 19 of the province's 47 sites offered safer inhalation services.[70]

FALLING SHORT

Ground zero for opioid-related deaths, BC has been a standout in harm reduction policies but support has been waning.

POPULATION MENTAL HEALTH

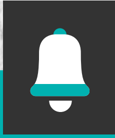
British Columbia reports some of the highest rates of harm due to substance and alcohol use in the country: the province's rate of apparent opioid toxicity deaths is 46.6 per 100,000 people, more than double the national rate (20.8/100,000), and hospitalization rates due to alcohol are higher than the national average. The lifetime prevalence rate of substance use disorders is also higher for BC (25.2%) compared to the national average (20.7%).

The rate of suicide in British Columbia is lower than the national rate (6.9 versus 10.9 /100,000). This marks a decline from previous years, in which reported rates were 11.6 (2019) and 10.6 per 100,000 (2021).[71]

SERVICE ACCESS

BC reports a higher distribution of psychiatrists (14.8 per 100,000 people) compared to the Canadian average (13.1). However, the data from other indicators in this report suggest that there may be other barriers to receiving MHASU health care. The reported rate of unmet/partially met need for MHASU care is higher in BC than the Canadian average (9.4% vs. 7.8%), and hospital readmission rates within 30 days are 15.3% compared to 13.4% across Canada.

British Columbia has, however, been leading the way in investing in early intervention services and crisis care reform. The BC government funds early intervention programs such as BounceBack and Confident Parents: Thriving Kids and, in 2023, it invested $75 million to expand Foundry services with the addition of 12 new centres.[72] The government has also committed to supporting 12 Peer Assisted Care Teams (PACTs), which are mobile and civilian-led crisis response teams that do not involve police.[73] Such alternative approaches to crisis response aim to decrease incidents that result in the harm of those in crisis and to support them with service navigation and trauma-informed resources.[74]



NOTEWORTHY

BC is leading the way in early intervention services and crisis care reform.

SOCIAL DETERMINANTS OF HEALTH

BC reports higher-than-average rates of housing unaffordability, homelessness, and poverty. The province has one of the largest populations of renters in Canada and is among one of the least affordable places to live. In Vancouver, the number of people who are unhoused has increased by 32% between 2020 and 2023. To address the housing and poverty crises, the BC government introduced new housing policy measures[75] and legislation to reduce poverty by 60% over the next decade.[76]

STIGMA AND DISCRIMINATION

With the exception of *Sense of belonging to community* (indicator 5.2), the other two indicators relating to stigma and discrimination in British Columbia underperform, suggesting weakness in supporting the human rights and wellness of people with poorer mental health in the province. On one hand, people who report “poor” or “fair” mental health in BC have a stronger sense of feeling connected to community than elsewhere in Canada, at 56.8%. On the other hand, approximately 10.9% of the population reporting poor-to-fair mental health say that they have experienced stigma or discrimination, marking British Columbia with the highest rate in Canada. Furthermore, in 2021, British Columbia reported the third highest rate of police-reported crime for drugs per 100,000 population: 343 versus the average of 162 per 100,000, a rate that should be read with caution as it may have changed during the decriminalization pilot.

HIGH ALERT

BC has the highest rate of stigma and discrimination in Canada.

IN FOCUS >

Mental health in ALBERTA

Population: 4,849,906 | **Rural:** 15.2%[77]

As unveiled in its new policy framework, Alberta is focused on recovery. The Government of Alberta recently announced the creation of Recovery Alberta, a new mental health and addictions organization that will be responsible for delivering mental health, addictions and substance use health (MHASU) services. Its mandates include improving access to treatment and services, which is important given Alberta's higher-than-average rates of suicide, poor mental health, substance use disorders and unmet need for services. Stigma and discrimination are areas of concern here: the reported rate of sense of belonging is lower here for people reporting poor-to-fair mental health. The Compassionate Intervention legislation that is being considered will mandate involuntary detention and treatment for people with substance use disorders, which harm reduction advocates signal could undermine the health and well-being of people who use drugs.

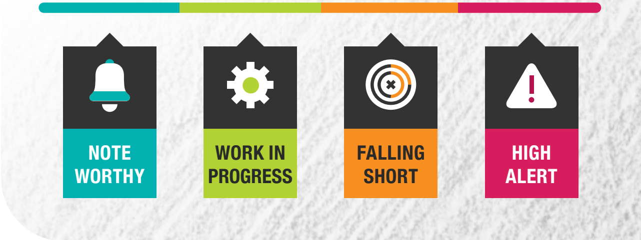
Grappling with a toxic drug supply for nearly a decade, Alberta has the second highest rate of apparent opioid toxicity deaths, and a higher rate of hospitalization due to alcohol harms, which signal a need to increase access to harm reduction services. Furthermore, the province faces a housing affordability crisis that needs policy attention.

IN FOCUS: ALBERTA

	Indicator	Indicator Category	AB	CAN
1.1a	Mental health, addictions, and substance use (MHASU) Healthcare Investments	Policy	5.5%	6.3%
1.1b	Bilateral Health Spending for MHASU	Policy	40%	31%
1.2	MHASU Strategy	Policy	Out of date	Out of date
1.3	Decriminalization policy	Policy	–	Low support
1.4	Harm reduction policy	Policy	Moderate support	High support
1.5	Mental Health Acts	Policy	High concern	–
2.1	Perceived mental health – poor/fair	Population Mental Health (MH)	29.3%	26.1%
2.2a	Prevalence of mood/anxiety disorders (12-month)	Population MH	11.9%	10.6%
2.2b	Prevalence of substance use disorders (lifetime)	Population MH	24.4%	20.7%
2.3	Rate of death by suicide	Population MH	14.3	10.9
2.4	Rate of hospitalization for self-harm	Population MH	52.2	64.9
2.5	Rate of apparent opioid toxicity deaths	Population MH	39.4	20.8
2.6	Rate of hospitalizations caused entirely by alcohol	Population MH	333	262
3.1	Percentage of population needing mental health care but needs are unmet or partially met	Service access	9.0%	7.8%
3.2	Percentage of youth with early MHASU service needs who accessed Community Mental Health services	Service access	62%	61%
3.3	Number of psychiatrists per 100,000 population	Service access	10.6	13.1
3.4	Supply of MHASU healthcare providers	Service access	1,907.2	1,721.4
3.5	30-day hospital readmission rates for MHASU concerns	Service access	11.3%	13.4%
4.1	Percentage of population reporting poor-to-fair mental health in core housing need	Social Determinants of Health (SDOH)	17.4%	15.8%
4.2	Poverty rate	SDOH	8.1%	8.1%
4.3	Employment rate for individuals with mental health disabilities (ages 25-64)	SDOH	53.9%	46.1%
5.1	Percentage of those with poor-to-fair mental health who experienced discrimination and victimization	Stigma and discrim	9.9%	9.1%
5.2	Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community	Stigma and discrim	49.7%	54.4%
5.3	Reported rate of drug-related offences	Stigma and discrim	146	162

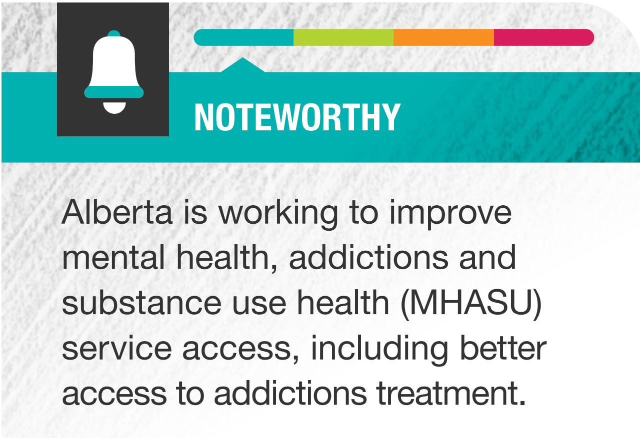
Note: Values in the table above that do not have a percentage indicate a rate per 100,000 population

IN FOCUS: ALBERTA



POLICY

Although Alberta does not have a formal mental health, addictions and substance use (MHASU) strategy, it has been public about its approach to improving MHASU care. Branded the "Alberta model" of care, the government's "recovery-oriented" policy framework was presented in a series of guidance documents, which puts treatment and service access at the forefront.[78] Each year, the Alberta Government releases a Mental Health and Addiction Business Plan along with its Budget Estimates. The Business Plan lays out key government investments in programs and services along with performance metrics for that year. A formal strategy would provide the community with a view into the government's longer-term plan.[79] In 2019, Alberta created A Provincial Action Plan for Youth Suicide Prevention (2019-2024) that includes a Youth Suicide Prevention Grant Program, the funding of which was increased in 2024 by $1 million for a total investment of $4 million over the next two years.



Following the release of its 2024-25 budget, the Government of Alberta announced the creation of Recovery Alberta, a new mental health and addictions service delivery organization (formerly part of Alberta Health Services). The funding allocated to Recovery Alberta as well as the new Canadian Centre of Recovery Excellence is $1.55 billion, which amounts to 5.5% of the province's overall health budget.

In Alberta's 2023 Bilateral Health Agreement with the federal government, which includes a renewed commitment to spend the remaining funds from the Shared Health Priorities Agreement from 2017, the province agreed to invest 40% of this funding in MHASU, which is higher than the average spending across Canada (31%).

Sections of the Mental Health Act were deemed unconstitutional by Alberta's Superior Trial Court and flagged by the Alberta Ombudsperson in 2019 due to the high number of complaints.[80] The Act has since been modernized (2020) with a commitment to monitor progress, although new complaints to the Ombudsperson raise concerns about how well the recommendations are being implemented and highlight the need for more work.[81] Since 2023, the Alberta government has been discussing legislation that would allow involuntary treatment for addiction, which has been criticized by human rights and harm reduction organizations.[82]

IN FOCUS: ALBERTA

Policy Response to the toxic drug crisis

In 2024, in response to the toxic drug crisis, the Alberta Government introduced the "Alberta Recovery Model," a policy framework drawn from the American Substance Abuse and Mental Health Services Administration's recovery-oriented system of care. This system focuses on opioid agonist therapies through both rapid access clinics and virtual clinics and bed-based care, with a considerable investment in treatment. In the lead-up to this policy announcement, the Government of Alberta froze funding in 2020 to supervised consumption sites and conducted an evidence review, which created additional requirements for the services to meet provincial standards for care. Currently, Alberta has four supervised consumption sites and two overdose prevention sites.[83] The Alberta Government also published a review of safer supply services and introduced "The Community Protection and Opioid Stewardship Standards," with the directive to make people transition from safer supply prescribing arrangements into opioid agonist treatment programs.[84] In light of the new policy orientation, advocates in Alberta are calling for a scale up of supervised consumption services, greater distribution of sterile equipment for drug use, and safer supply.[85]

POPULATION MENTAL HEALTH

At 14.3 deaths/100,000 people, the rate of suicide in Alberta is higher than the national average of 10.9/100,000. Half of all suicide deaths in Alberta occur in Edmonton and Calgary. Suicide is of particular concern for First Nations communities in Northern Alberta. The rate is higher in communities with limited access to mental health care and supports, notably in rural areas of the province and First Nations communities. Recently, a council representing five First Nations in the region declared a local state of emergency due to the rise in suicide deaths.[86] Furthermore, workers—particularly men—within many of Alberta's industries are at elevated risk for suicide due to the challenges associated with working in isolation, in physically demanding roles, and under the unpredictable pressures of farming, ranching and fossil fuel energy production.

Alberta records the second highest number of deaths due to opioid toxicity, after British Columbia. The 2022 rate, which was 32.9 deaths per 100,000 people, has since risen to 39.4 deaths per 100,000, which is far higher than the national average (20.8 deaths/100,000). First Nations peoples in Alberta are disproportionately represented in the number of deaths compared to the non-First Nations population. First Nations persons accounted for 22% of all opioid deaths in 2020, although they represent 6% of Alberta's population.[87]

HIGH ALERT

Suicide state of emergency and rampant opioid toxicity deaths in First Nations communities.

SERVICE ACCESS

Albertans face challenges accessing the MHASU services and supports they need. The percentage of Albertans with unmet MHASU needs is higher than the national average: 9% vs. 7.8%. A higher number of Albertans are seeking mental health care in hospital emergency rooms: 10.8% compared to 9.5% nationally. In addition, a lower number of psychiatrists work in the province: 10.6/100,000 compared to 13.1/100,000 nationally.

Access to services is particularly limited in rural parts of the province where rural Albertans are seeking out mental health supports wherever they can. According to a recent report by the Alberta Centre for Sustainable Rural Communities, there is increasing pressure on Family and Community Support Services (FCSS) in rural Alberta.[88] While FCSS mainly offers preventative social services, they are facing increasing demands from clients for mental health support, as well as income, food and shelter supports.

FALLING SHORT

Many people seek mental health care in Emergency Departments.

SOCIAL DETERMINANTS OF HEALTH

Housing affordability is at a crisis point in Alberta. Population growth, coupled with limited housing supply,[89] has contributed to a 20% jump in rents in the last year, the highest increase of all provinces and territories in Canada.[90] The data show that Albertans with poor-to-fair mental health face a core housing need (17.4%) greater than the national average (15.8%). Low-income Albertans are particularly vulnerable to housing insecurity. In 2022, the wage needed for a one-bedroom apartment in Alberta was $21.42/hour, significantly higher than the current $15/hour minimum wage.[91] This suggests that low-income Albertans face significant barriers to accessing adequate and affordable housing. Currently, there are no rent controls in Alberta.[92]

STIGMA AND DISCRIMINATION

Albertans reporting poor-to-fair mental health experience slightly more incidences of discrimination and victimization than average in Canada (9.9% vs 9.1%) and report a lower sense of feeling connected to community (49.7% compared to 54.4% nationwide). The rate of drug-related offences in the province is 146 per 100,000, lower than the national rate 162 per 100,000.

IN FOCUS >

Mental health in SASKATCHEWAN

Population: 1,231,043 | **Rural:** 31.7%

With a new mental health action plan and a budget for mental health, addictions and substance use (MHASU) health care that exceeds the Canadian average, Saskatchewan is well poised to improve access to mental health, addictions and substance use health services. This is timely action given psychiatrists are hard to attract and retain, and youth are struggling more here than elsewhere in the country. Saskatchewan reports some of the highest rates of mood, anxiety and substance use disorders, and the suicide and self-harm rates are higher in this province; alarmingly so for First Nations people.

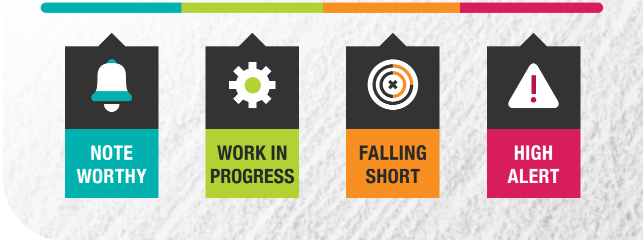
The Saskatchewan government has introduced both a suicide action plan and legislation and is working with First Nations on the implementation. Despite high levels of opioid-related deaths, Saskatchewan has taken a treatment-oriented approach to the crisis and has signaled it will not support safer supply. It will need to improve its policy framework for substance use and harm reduction to address the crisis.

IN FOCUS: SASKATCHEWAN

Indicator		Indicator Category	SK	CAN
1.1a	Mental health, addictions, and substance use (MHASU) Healthcare Investments	Policy	7.5%	6.3%
1.1b	Bilateral Health Spending for MHASU	Policy	35%	31%
1.2	MHASU Strategy	Policy	Moderately comprehensive	Out of date
1.3	Decriminalization policy	Policy	–	Low support
1.4	Harm reduction policy	Policy	Moderate support	High support
1.5	Mental Health Acts	Policy	Ins.	–
2.1	Perceived mental health – poor/fair	Population Mental Health (MH)	25.3%	26.1%
2.2a	Prevalence of mood/anxiety disorders (12-month)	Population MH	15.5%	10.6%
2.2b	Prevalence of substance use disorders (lifetime)	Population MH	27.5%	20.7%
2.3	Rate of death by suicide	Population MH	17.6	10.9
2.4	Rate of hospitalization for self-harm	Population MH	87.7	64.9
2.5	Rate of apparent opioid toxicity deaths	Population MH	24	20.8
2.6	Rate of hospitalizations caused entirely by alcohol	Population MH	375	262
3.1	Percentage of population needing mental health care but needs are unmet or partially met	Service access	6.6%	7.8%
3.2	Percentage of youth with early MHASU service needs who accessed Community Mental Health services	Service access	48%	61%
3.3	Number of psychiatrists per 100,000 population	Service access	7.4	13.1
3.4	Supply of MHASU healthcare providers	Service access	1,907.2	1,721.4
3.5	30-day hospital readmission rates for MHASU concerns	Service access	11.5%	13.4%
4.1	Percentage of population reporting poor-to-fair mental health in core housing need	Social Determinants of Health (SDOH)	16.3%	15.8%
4.2	Poverty rate	SDOH	8.4%	8.1%
4.3	Employment rate for individuals with mental health disabilities (ages 25-64)	SDOH	58.8%	46.1%
5.1	Percentage of those with poor-to-fair mental health who experienced discrimination and victimization	Stigma and discrim	9.9%	9.1%
5.2	Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community	Stigma and discrim	51.8%	54.4%
5.3	Reported rate of drug-related offences	Stigma and discrim	206	162

Note: Values in the table above that do not have a percentage indicate a rate per 100,000 population

IN FOCUS: SASKATCHEWAN



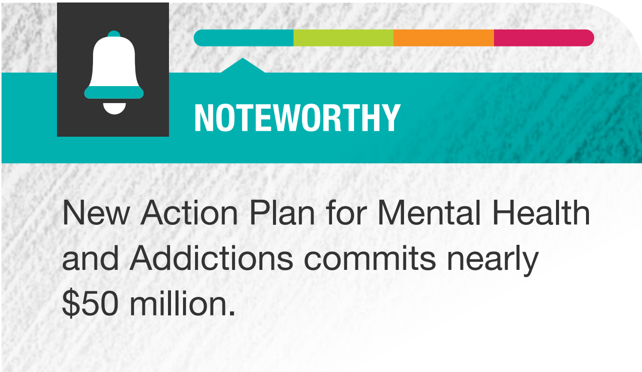
POLICY

Funding

Budget 2024-2025 commits $574 million for mental health and addictions, which is 7.5% of overall health care spending. This percentage is on the higher end of what most provinces and territories spend on average. In the 2023 Bilateral Health Agreement with the federal government (which also includes a renewed commitment to spend the remaining funds from the Shared Health Priorities Agreement from 2017), Saskatchewan agreed to invest 35% of this total funding towards MHASU, which is also slightly higher than the average across Canada (31%).

Strategy

Last year, Saskatchewan released a new Action Plan for Mental Health and Addictions (2023-2028) . The plan includes adding 500 new addictions treatment spaces, rapid access to MHASU services and a central intake system for mental health services. Although the Strategy is light on details about funding and timelines, the government commits that by year five of the plan, it will have spent $49.4M on the action items. The plan is branded as investing in a "Recovery-Oriented System of Care" and does not include any new plans to invest in harm reduction.[93]



Policy Response to the toxic drug crisis

Despite harms from the toxic drug supply, the Government of Saskatchewan continues to prioritize treatment models of care for substance use.[94] While it does provide funding for naloxone and drug checking, including fentanyl test strips at 30 locations across the province and FTIR spectrometers at two overdose/supervised prevention sites (OPS/SCS),[95] the government does not fund the operation of the OPS/SCS, which are supported municipally and through donations. It has also stated its intention not to support safer supply initiatives and, in January 2024, the government announced that it will no longer provide funding to third-party organizations to supply sterile equipment to people who use drugs.[96]

POPULATION MENTAL HEALTH

Saskatchewan reports the highest rates of mood (15.6%) and anxiety (15.4%) disorders in Canada and the second highest rate of substance use disorders (27.5%), after New Brunswick.

A report on suicide from 2006-2020 found that the rate of suicide for First Nations people is five times higher than in the non-First Nations population, and that the rates of self-harm for First Nations girls is seven times higher than for girls who are not First Nations.[97] Organizations have been urging the government to take action. The Federation of Sovereign Indigenous Nations developed its own Indigenous-specific suicide strategy in 2018, in light of the inaction.[98] In 2020, the Saskatchewan government released a suicide prevention strategy and in 2021, passed the *Strategy for Suicide Prevention Act*. It is working with Indigenous partners and releasing annual reports to measure progress on suicide prevention.

Saskatchewan is also experiencing a high number of deaths due to toxic drugs. While the rate of apparent opioid toxicity deaths has thankfully been trending downwards since the record number reported during the pandemic,[99] last year Saskatchewan reported 24 per 100,000 deaths—higher than the Canadian average (20.8 per 100,000). The data available so far for 2023 show that opioid-related deaths are once again on the rise.

SERVICE ACCESS

Data related to service access suggest that Saskatchewan may be doing better than the Canadian average for some services, as the province reports some of the lowest hospital re-admission rates for MHASU concerns (11.5 per 100,000) in all of Canada. However, Saskatchewan is struggling when it comes to youth mental health and access to psychiatrists and, alarmingly, reports some of the highest rates of suicide and hospitalization for self-harm in the country.

Only 48% of youth with early MHASU needs have accessed services in the province, compared to 61% of youth across Canada. The Saskatchewan Advocate for Children and Youth has declared the poor access to mental health services for youth to be a crisis. Saskatchewan also faces challenges attracting and retaining psychiatrists, with only 7.4 psychiatrists per 100,000. The government is trying to address this poor access, especially for youth, by providing limited funding to the College of Medicine for subspecialty training in child psychiatry.[100]

HIGH ALERT

A crisis number of youth aren't getting the mental health, addictions and substance use (MHASU) help they need. First Nations girls are at very high risk of self harm.

WORK IN PROGRESS

With few psychiatrists, Saskatchewan is funding subspecialty training in child psychiatry.

SOCIAL DETERMINANTS OF HEALTH

Saskatchewan's rate of employment for people with mental health disabilities is higher than the national average (58.8% compared to 46.1%). The rate of core housing need for those with poor-to-fair mental health is slightly above average at 16.3% compared to the national average of 15.8%. Saskatchewan's poverty rate is 8.4%, marginally higher than the national average of 8.1%.

STIGMA AND DISCRIMINATION

Fewer-than-average Saskatchewan residents with poor-to-fair mental health report that they feel a strong sense of belonging to community. This same population reports a slightly higher-than-average rate of discrimination and victimization (9.9% versus 9.1%). The rate of drug-related offences in Saskatchewan is 206 per 100,000 people, which is higher than the national rate of 162 per 100,000.

IN FOCUS >

Mental health in MANITOBA

Population: 1,484,135 | **Rural:** 25.3%

In Manitoba, mental healthcare needs are high. Youth, particularly those in rural and remote areas, have not been getting the mental health, addictions and substance use (MHASU) health care they need. Suicide is the leading cause of death for youth ages 10-17 and the suicide rate among Indigenous peoples is 4.6 times higher than the rest of the province. A recent announcement promised an increase in community-based MHASU services and reduced wait times for youth by 2026. While Manitoba has a current MHASU strategy for improving services, it is weak on timelines, evaluation and accountability.

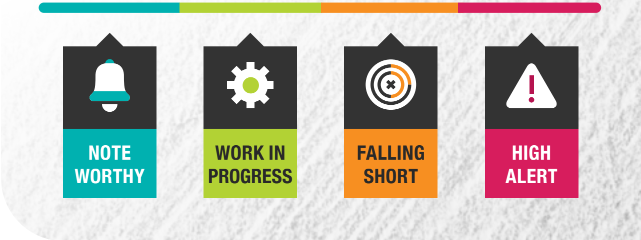
Of major concern is the rate of child poverty—the highest among the provinces—and the large number of Indigenous and racialized Winnipeg residents living in poverty. The new government has announced funding for a supervised consumption site, signaling a change in Manitoba's previously weak approach to harm reduction.

IN FOCUS: MANITOBA

	Indicator	Indicator Category	MB	CAN
1.1a	Mental health, addictions, and substance use (MHASU) Healthcare Investments	Policy	5.6%	6.3%
1.1b	Bilateral Health Spending for MHASU	Policy	15%	31%
1.2	MHASU Strategy	Policy	Somewhat comprehensive	Out of date
1.3	Decriminalization policy	Policy	–	Low support
1.4	Harm reduction policy	Policy	Moderate support	High support
1.5	Mental Health Acts	Policy	Low concern	–
2.1	Perceived mental health – poor/fair	Population Mental Health (MH)	27.3%	26.1%
2.2a	Prevalence of mood/anxiety disorders (12-month)	Population MH	10.5%	10.6%
2.2b	Prevalence of substance use disorders (lifetime)	Population MH	24.5%	20.7%
2.3	Rate of death by suicide	Population MH	13.9	10.9
2.4	Rate of hospitalization for self-harm	Population MH	38.7	64.9
2.5	Rate of apparent opioid toxicity deaths	Population MH	3.7	20.8
2.6	Rate of hospitalizations caused entirely by alcohol	Population MH	259	262
3.1	Percentage of population needing mental health care but needs are unmet or partially met	Service access	8.4%	7.8%
3.2	Percentage of youth with early MHASU service needs who accessed Community Mental Health services	Service access	52%	61%
3.3	Number of psychiatrists per 100,000 population	Service access	13.3	13.1
3.4	Supply of MHASU healthcare providers	Service access	1,862.2	1,721.4
3.5	30-day hospital readmission rates for MHASU concerns	Service access	10.7%	13.4%
4.1	Percentage of population reporting poor-to-fair mental health in core housing need	Social Determinants of Health (SDOH)	14.7%	15.8%
4.2	Poverty rate	SDOH	8.6%	8.1%
4.3	Employment rate for individuals with mental health disabilities (ages 25-64)	SDOH	51.6%	46.1%
5.1	Percentage of those with poor-to-fair mental health who experienced discrimination and victimization	Stigma and discrim	9.9%	9.1%
5.2	Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community	Stigma and discrim	54.5%	54.4%
5.3	Reported rate of drug-related offences	Stigma and discrim	158	162

Note: Values in the table above that do not have a percentage indicate a rate per 100,000 population

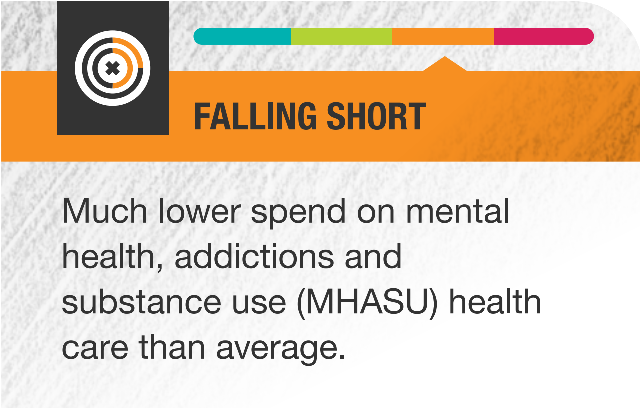
IN FOCUS: MANITOBA



POLICY

Funding

Manitoba's spending on mental health, addictions and substance use (MHASU) care is unknown for 2024-2025. In 2023-24, Manitoba spent approximately $439 million on mental health, which amounts to 5.6% of the overall health budget. Manitoba is dedicating a much lower share of its bilateral health funding to MHASU. The *Working Together Agreement* (2023 Bilateral Health Agreement) and the remaining funds from the Shared Health Priorities Agreement (2017) combined represent 15% of the total bilateral healthcare funding destined to be spent between 2023-2026, which is significantly lower than the Canadian average (31%).



Strategy

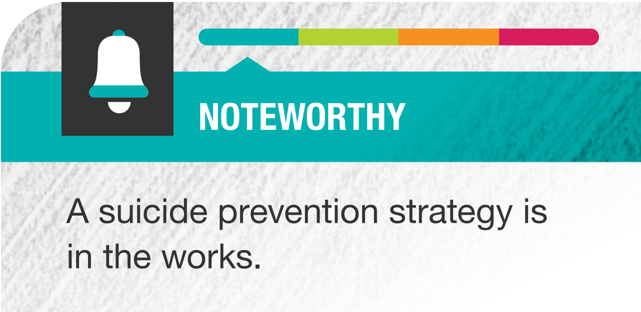
Manitoba has an active MHASU strategy and plans to implement a new suicide prevention strategy.[101] The MHASU strategy, *A Pathway to Mental Health and Community Wellness* (2022), is a five-year framework for improving MHASU services in Manitoba; however, while it lists areas of improvement, the strategy does not present clear timelines, a funding plan, performance measures or an accountability framework.

Policy Response to the toxic drug crisis

Manitoba's policy support for harm reduction has been weak historically despite the mounting drug toxicity crisis. With the exception of naloxone distribution,[102] the government previously had not supported or funded harm reduction measures. In 2023, it introduced legislation that would create additional barriers, including a provincial licensing requirement for organizations applying to operate a supervised consumption site and for some existing addictions treatment services.[103] The newly elected NDP government, however, announced that it will commit $2.5 million to open a supervised consumption site in 2025, signaling that changes may be afoot for Manitoba's harm reduction policy.[104]

POPULATION MENTAL HEALTH

Concerningly, Manitoba's suicide rate is higher than the Canadian average (13.9 compared to 10.9 deaths/100,000 people). Indigenous communities in Manitoba are disproportionately impacted by suicide: the rate of suicide for Indigenous people in the province is 4.6 times higher than for non-Indigenous people, and the high rates in several communities have prompted a declaration of a state of emergency.[105] The Working Together Agreement announced that a comprehensive, province-wide Suicide Prevention Strategy is currently under development and that the new strategy will include a focus on Indigenous peoples and 2SLGBTQ+ youth.[106]



In 2022, Manitoba reported a lower rate of mortality from apparent opioid drug poisonings compared to the Canadian average (3.7 compared to 20.8 per 100,000). The number of deaths peaked rapidly and dramatically over the pandemic, climbing from 4.5 deaths per 100,000 in 2019 to 19.4 in 2021.[107] The current rate of 3.7 per 100,000 marks a historic low for the province. However, Manitoba reports a higher lifetime prevalence rate of substance use disorders (SUDs): 24.5% compared to the Canadian average of 20.7%.

SERVICE ACCESS

It is challenging to piece together Manitoba's landscape for MHASU service access based on the indicators presented in this report. On one hand, Manitoba youth in need of MHASU services have considerably lower rates of access compared to the national average (52% compared to 61%). Of the population reporting a need for MHASU care, a higher percent than the average says their needs were unmet or only partially met (8.4%). On the other hand, the size of the MHASU workforce and the number of psychiatrists in the province per 100,000 population are both slightly above average.

WORK IN PROGRESS

With suicide the leading cause of death for youth, new services and shorter waits are promised by 2026.

Organizations in Manitoba report strong inequities that limit access to appropriate care for youth, especially in remote and rural areas of the province. Indigenous youth in particular face stigma, systemic racism, and discrimination when accessing services.[108] Access to care is especially salient given that suicide is the leading cause of death for Manitoba youth ages 10-17 and given that the province declared the youth suicide rate in 2022-2023 the province's highest on record.[109] Considering the high unmet need for services among Manitoba youth, the recent announcement to expand the availability of community-based MHASU services and reduce wait times for youth by 2026 is significant.[110]

Manitoba's large rural population experiences challenges in getting access to services. The Manitoba government recently announced $450,000 over the next three years to support farmers' mental health through the Manitoba Farmer Wellness Program.[111]

SOCIAL DETERMINANTS OF HEALTH

Although the poverty rate in Canada was trending downwards in the 2020 census data, the fact that the national rate is still 8.1%—and is projected to rise again—is a serious concern.[112] At 8.3%, Manitoba's rate is even higher than the national average, and when the data is disaggregated by race, even greater inequity comes to light. Census data from 2020 shows that poverty disproportionately affects Indigenous and racialized peoples in Manitoba. In Winnipeg, which has the largest Indigenous population of all urban centres in Canada, 23.2% of First Nations people, 10.5% of Métis and 14.4% of Inuit live in poverty. That same year, the rate among Black and Latino/a residents in Winnipeg was reported to be 15.8% and 16.3%.[113] As pandemic benefits have come to an end, child poverty is also on the rise again, and Manitoba reported the highest rate of child poverty among the provinces at 27.2% in 2021 (compared to the Canadian average of 16.1%).[114]

HIGH ALERT

Highest child poverty rate of all the provinces

STIGMA AND DISCRIMINATION

The percentage of Manitobans reporting poor-to-fair mental health who feel a strong connection to community is on par with the national average. A slightly higher percentage report experiencing discrimination and victimization (9.9% compared to 9.1% for all of Canada). The reported rate of drug-related offences is 158 per 100,000 people, slightly lower than the national rate 162 per 100,000.

IN FOCUS >

Mental health in ONTARIO

Population: 15,996,989 | **Rural:** 17%

In the aftermath of the pandemic, Ontario saw a dramatic increase in mental health and addictions-related harms, including due to opioids and alcohol. Long wait times for counseling and other mental health services continue to be a problem, especially for youth. Ontario's entire healthcare sector is facing a crisis in health human resources (HHR), including a shortage of mental health service providers. While a higher number of psychiatrists are practicing in the larger urban centres, this is not the case in rural and remote areas of the province.

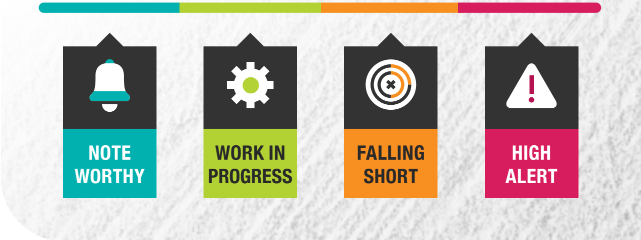
The Ontario Government has been shifting its policy support for harm reduction to bed-based addictions care. Concerningly, Ontario has the second highest rates of core housing need after BC, with housing unaffordability affecting many Ontarians.

IN FOCUS: ONTARIO

Indicator		Indicator Category	ON	CAN
1.1a	Mental health, addictions, and substance use (MHASU) Healthcare Investments	Policy	5.9%	6.3%
1.1b	Bilateral Health Spending for MHASU	Policy	40.5%	31%
1.2	MHASU Strategy	Policy	Moderately comprehensive	Out of date
1.3	Decriminalization policy	Policy	–	Low support
1.4	Harm reduction policy	Policy	Low support	High support
1.5	Mental Health Acts	Policy	Moderate concern	–
2.1	Perceived mental health – poor/fair	Population Mental Health (MH)	26.4%	26.1%
2.2a	Prevalence of mood/anxiety disorders (12-month)	Population MH	10.9%	10.6%
2.2b	Prevalence of substance use disorders (lifetime)	Population MH	18.9%	20.7%
2.3	Rate of death by suicide	Population MH	9.6	10.9
2.4	Rate of hospitalization for self-harm	Population MH	63.0	64.9
2.5	Rate of apparent opioid toxicity deaths	Population MH	16.6	20.8
2.6	Rate of hospitalizations caused entirely by alcohol	Population MH	214	262
3.1	Percentage of population needing mental health care but needs are unmet or partially met	Service access	7.8%	7.8%
3.2	Percentage of youth with early MHASU service needs who accessed Community Mental Health services	Service access	61%	61%
3.3	Number of psychiatrists per 100,000 population	Service access	13.4	13.1
3.4	Supply of MHASU healthcare providers	Service access	1,609.9	1,721.4
3.5	30-day hospital readmission rates for MHASU concerns	Service access	13.7%	13.4%
4.1	Percentage of population reporting poor-to-fair mental health in core housing need	Social Determinants of Health (SDOH)	18.1%	15.8%
4.2	Poverty rate	SDOH	8.3%	8.1%
4.3	Employment rate for individuals with mental health disabilities (ages 25-64)	SDOH	43%	46.1%
5.1	Percentage of those with poor-to-fair mental health who experienced discrimination and victimization	Stigma and discrim	10.3%	9.1%
5.2	Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community	Stigma and discrim	55.4 %	54.4%
5.3	Reported rate of drug-related offences	Stigma and discrim	98	162

Note: Values in the table above that do not have a percentage indicate a rate per 100,000 population

IN FOCUS: ONTARIO



POLICY

Funding

In 2024-25, Ontario will spend approximately $2 billion on mental health, which amounts to 5.9% of the overall health budget. Ontario is dedicating a higher share of its bilateral health funding to mental health, addictions and substance use (MHASU) health care. Combined, the *Working Together Agreement* (2023 Bilateral Health Agreement) and the renewed commitment for the Shared Health Priorities Agreement (2017) dedicate 40.5% of their total funding to mental health, addictions and substance use (MHASU) (for the 2023-2026 cycle), which is higher than the Canadian average (31%).

Strategy

Ontario has a MHASU strategy (*Roadmap to Wellness*, 2020-2030) that commits $3.8 billion over 10 years to MHASU health care. The plan has three core areas: addressing long wait times, funding shortfalls, and increasing data on MHASU service need and uptake. The strategy created the Mental Health and Addictions Centre of Excellence to collect data and improve systems performance, which is important given the higher-than-average barriers to service access reported here.[115]

10-year strategy will close care gaps for those with highest needs but does not look at preventing worsening mental health.

While *Roadmap to Wellness* strives to build an evidence-based, accessible MHASU system, the primary focus is on the most acute care. The strength of this approach is that service gaps for those in urgent need will be addressed first, but the shortcoming is that it does not look upstream to prevent worsening mental health.

In the 2023 budget, community mental health organizations received a much needed and one-time 5% boost to their base funding, the first increase in over a decade. However, longstanding concerns linger. Healthcare investments, including for MHASU, continue to be "physician-centered" which has inherent limitations for meeting the MHASU healthcare needs in the province.[116] The pay equity gap between the community health sector and other parts of the health system (such as hospitals) means that healthcare workers employed in community mental health settings are often paid 20 to 30 per cent less than healthcare workers employed in other health care settings, creating a health human resources (HHR) crisis in Ontario's community mental health and addictions services.

Bump in investment to community mental health organizations in 2023, but pay equity gap puts pressure on their workforce.

Policy response to the toxic drug crisis

Greater policy action is needed to support the health of people who use drugs in Ontario. Ontario is experiencing mounting harms stemming from the toxic drug supply; however, the government's policy response has not kept up with population health needs. Despite the high rates of harm, support for harm reduction has waned over recent years. In 2021, the Ontario Government introduced a new model known as "Consumption and Treatment Services" (CTS), which capped the number of sites and created additional requirements for the services to operate.[117] In the fall of 2023, the province launched a "critical incident review" (the Review) of CTS sites, and, citing safety issues, paused approval of new sites, and froze all new funding for CTS sites.

In August 2024, the government released the Review and announced they were banning CTS sites within 200 metres of schools and child-care centres which would result in the closure of nine provincially funded sites and one self-funded site. It also plans to introduce legislation to prohibit municipalities or any organization from starting new CTS sites; participating in safe supply initiatives; or requesting the decriminalization of illegal drugs from the federal government. The closure of any CTS site was not recommended in the Review.

The Ontario Government is not supportive of many forms of harm reduction to address substance use harms or the drug poisoning crisis. The province's policy focus remains on bed-based addictions care without consideration of the continuum of care needed to fully support people who are managing addiction or substance use.

POPULATION MENTAL HEALTH

When it comes to the population mental health indicators, Ontario's rates are similar to the national average. The prevalence of poor or fair mental health (26.4% compared to 26.1) and mood and anxiety disorders (10.9% compared to 10.6%) are marginally higher than the Canadian average, while the rate of SUDs is slightly lower (18.9% compared to 20.7%). Although the rate of apparent opioid toxicity deaths for Ontario is also lower than the Canadian average, at 16.6 per 100,000 compared to Canada's rate of 20.8 per 100,000, this is a significant hike from the pre-pandemic 2019 rate, which was 10.6 per 100,000.

SERVICE ACCESS

While Ontario is close to the Canadian average for access to services, the need for better access is evident: in 2021, Ontario Health reported a 47% increase in emergency department visits and a 23% rise in the hospitalization rate for MHASU health care. In particular, the hospitalization rate for youth ages 14-17 with MHASU concerns has increased by 136%.[118] Although the number of psychiatrists in Ontario is higher than the Canadian average per 100,000, the distribution of psychiatrists *within* the province is inequitable. Research has found a greater number of practitioners clustered in urban areas and serving populations with lower needs.[119]

To address some of the barriers to access, the Ontario government expanded the Ontario Structured Psychotherapy Program (OSP), which provides free cognitive behavioural therapy for people experiencing depression and anxiety. The program offers various levels of support based on need, and services are delivered by trained mental health coaches or clinicians over the phone, virtually, or in person.

HIGH ALERT

Off-the-charts increase for youth mental health, addictions and substance use (MHASU) related visits to Emergency Departments (136%).

SOCIAL DETERMINANTS OF HEALTH

Ontario is facing a housing crisis. There's a shortage of housing stock and home prices and rents in many urban areas have risen faster than incomes.[120] At 18.1%, the core housing need among people reporting poor-to-fair mental health is higher than the Canadian average (15.8%). The housing problem is intertwined with poverty, which disproportionately impacts people with mental illnesses. Housing is often unaffordable for a significant number of recipients of income assistance. Among those who receive disability income supports in Ontario, up to 50% report having a mental illness or substance use disorder.[121]

FALLING SHORT

Housing crisis hitting people with mental illnesses especially hard.

Poverty, food insecurity, lack of social connection, and lack of housing all contribute to the deterioration of a person's mental health, and supportive housing models are crucial for many people with mental illnesses and addictions. However, the capital and operational funding for supportive housing in Ontario is often uncoordinated, with different models for agencies and the private market. Rent supplements help maintain stable housing but cannot keep up with competitive market rents in Ontario's urban areas and are of no value in areas where there is no housing supply. Due to stigma, clients needing supportive housing face additional barriers to renting in the private market.

The creation of new supportive housing requires the coordination of all three levels of government to fund new builds, allow zoning permissions, and with community agencies to provide the support services.

STIGMA AND DISCRIMINATION

The rate of drug offences is lower in Ontario, at 98 offences per 100,000 compared to the Canadian average of 162 per 100,000. This may in part be driven by a reduction in the number of drug possession cases in Ontario which dropped by 40.5% between 2019 and 2021. However, there are some regions where the rates were virtually unchanged, suggesting that the federal guidelines not to prosecute for simple possession were not equally heeded throughout the province.[122]

IN FOCUS >

Mental health in QUÉBEC

Population: 9,030,684

Rural: 19%

Québec stands out with its lower cost of living and progressive social policies, scoring higher on several of the population mental health indicators and with its lower rates of poverty and core housing need. However, exceptions include higher rates of suicide and self-harm, especially for northern Indigenous populations, who experience an extremely high suicide rate and often live in inadequate housing conditions. Québec has a strong mental health strategy that comes with considerable spending, but the provincial budget and the new 2023 *Working Together Bilateral Agreement* do not state where the money will be spent.

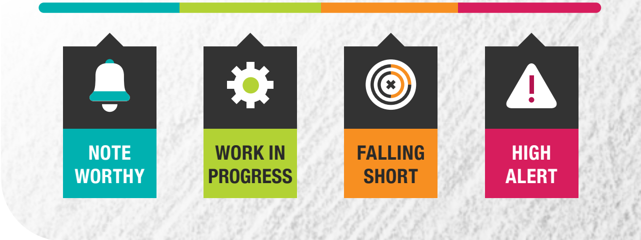
The private system of health care in Québec is growing, a trend that is concerning. It compromises access to care and has resulted in a high number of the mental health, addictions and substance use health (MHASU) workforce increasingly moving into higher wage jobs in the private sector. This is also true for family physicians, which are in the shortest supply here than in all of Canada.

IN FOCUS: QUÉBEC

	Indicator	Indicator Category	QC	CAN
1.1a	Mental health, addictions, and substance use (MHASU) Healthcare Investments	Policy	Ins.	6.3%
1.1b	Bilateral Health Spending for MHASU	Policy	–	31%
1.2	MHASU Strategy	Policy	Highly comprehensive	Out of date
1.3	Decriminalization policy	Policy	–	Low support
1.4	Harm reduction policy	Policy	Moderate support	High support
1.5	Mental Health Acts	Policy	Moderate concern	–
2.1	Perceived mental health – poor/fair	Population Mental Health (MH)	18.4%	26.1%
2.2a	Prevalence of mood/anxiety disorders (12-month)	Population MH	8.6%	10.6%
2.2b	Prevalence of substance use disorders (lifetime)	Population MH	17.1%	20.7%
2.3	Rate of death by suicide	Population MH	12.2	10.9
2.4	Rate of hospitalization for self-harm	Population MH	68.9	64.9
2.5	Rate of apparent opioid toxicity deaths	Population MH	6.0	20.8
2.6	Rate of hospitalizations caused entirely by alcohol	Population MH	210*	262
3.1	Percentage of population needing mental health care but needs are unmet or partially met	Service access	6.6%	7.8%
3.2	Percentage of youth with early MHASU service needs who accessed Community Mental Health services	Service access	–	61%
3.3	Number of psychiatrists per 100,000 population	Service access	14.4	13.1
3.4	Supply of MHASU healthcare providers	Service access	1,817.0	1,721.4
3.5	30-day hospital readmission rates for MHASU concerns	Service access	13.0%	13.4%
4.1	Percentage of population reporting poor-to-fair mental health in core housing need	Social Determinants of Health (SDOH)	9.9%	15.8%
4.2	Poverty rate	SDOH	6.4%	8.1%
4.3	Employment rate for individuals with mental health disabilities (ages 25-64)	SDOH	41.6%	46.1%
5.1	Percentage of those with poor-to-fair mental health who experienced discrimination and victimization	Stigma and discrim	5.6%	9.1%
5.2	Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community	Stigma and discrim	53.7%	54.4%
5.3	Reported rate of drug-related offences	Stigma and discrim	167	162

Note: Values in the table above that do not have a percentage indicate a rate per 100,000 population

IN FOCUS: QUÉBEC



POLICY

Funding

The Government of Québec did not clearly lay out how much or where it plans to spend on mental health, addictions and substance use (MHASU) care in its 2024-2025 budget. The new *Working Together Agreement* (2023 Bilateral agreement) and the Shared Health Priorities agreement (2017 Bilateral agreement) commit $1.98 billion and $531 million between 2023-2027.[123] The amount dedicated to MHASU and specific priorities for investment are also unknown, given that the Governments of Canada and Québec entered into an asymmetrical agreement that, following past practice, respects Québec's jurisdiction over health.[124]

Strategy

Québec has a robust mental health strategy, *S'unir pour un mieux-être collectif* (2022-2026). It covers a 5-year period and comes with a commitment to spend $1.15 billion. The action plan outlines 43 specific actions and initiatives under the umbrella of seven broad areas which include support for community mental health and crisis support services. Each action is accompanied by a projected investment as well as indicators for measuring progress.[125]

Mental Health Act

Québec's mental health law, the *Mental Patients Protection Act*, is the only one in Canada based on civil code. The law is generally regarded as strongly rights-based, given that people detained involuntarily have the right to refuse treatment unless it is authorized by a court.[126] However, the strong protections against involuntary treatment in Québec's Mental Health Act mean that those who need treatment may not receive it, even though they might be very ill and need care.[127]

Policy response to the toxic drug crisis

The Government of Québec supports some harm reduction measures but there is room to strengthen its policy. Québec funds three permanent and one mobile supervised consumption sites as well as four overdose prevention sites.

The sites offer drug checking, including some sophisticated technologies like mass spectrometry and colorimetric testing in addition to fentanyl test strips. The Government of Québec has noted its support for safer supply.

One of the recommendations in its recent substance use strategy, *Parce que chaque vie compte: Stratégies nationale de prévention des surdoses de substances psychoactives* 2022-2025, includes developing a policy framework for safer supply.[128] However, the strategy does not include plans or funding to do so. Nevertheless, there are some physicians in Québec who prescribe safer supply and the Government of Québec manages SUAP (federal government) funds for one safer supply program.

POPULATION MENTAL HEALTH

Québec reports the lowest prevalence of mental illnesses and substance use disorders and the highest rates of good mental health across Canada. The percentage of Québecers reporting poor-to-fair mental health is 18.4% compared to Canada's 26.1%, and the rates of prevalence for mood disorders (8.3%), anxiety (8.9%) and substance use disorders (17.1%) are significantly lower than the Canadian averages.

The rate of suicide in Québec is slightly higher than the national average, with an incidence of 12.2/100,000 people, compared to 10.9/100,000. It is important to note that suicide rates in Québec have been on a slow decline since 1981, while the rates of hospitalization for self-harm are on the rise.[129] There are key exceptions to this downward trend. In 2019, the rate of suicide in Nunavik, northern Québec, when adjusted to 100,000 population,[130] is 177.1 compared to Québec's overall suicide rate of 13.1/100,000. The rates of young women ages 15-34 presenting to emergency departments with suicidal ideation and who are hospitalized for self-harm also rose between 2008-2022.[131]

Québec reports a lower incidence of deaths related to opioid toxicity compared to the national average (6.0 vs. 20.8/100,000). However, the number of deaths is on the rise. In 2022, it more than doubled, from 284 deaths in 2021 to 540 in 2022.[132]

SERVICE ACCESS

The landscape of mental health, addictions and substance use (MHASU) service access in Québec is complex. While the province has a higher number of MHASU practitioners (2,067 per 100,000) compared to the Canadian average of 1,721 per 100,000, Québec also has the highest number of people who do not have a family doctor.

HIGH ALERT

One in five Quebecers doesn't have a family doctor.

In Québec, 21.6% of the population, compared to 14.5% nationally, do not have regular access to care, which has been linked to the number of doctors working in the private system (where the pay is higher) and to the practice in Québec of mandating new physicians to do compulsory shifts in short-staffed health facilities.[133] A poll conducted by Québec public sector psychologists found that the wait times for psychotherapy were typically between 6-24 months.[134]

The long wait times are linked to a larger concern that the public sector MHASU workforce is being lost to the private sector at an alarming rate.[135] Québec's rate of hospital readmission rates for a MHASU concern are near average, at 13% compared to 13.4%.

FALLING SHORT

Long wait times for psychotherapy are due to loss of workforce to private sector.

SOCIAL DETERMINANTS OF HEALTH

The percentage of Québecers in core housing need with poor-to-fair mental health (9.8% of the province's population) is two-thirds lower than the core housing need in Canada (15.8%). Historically, the cost of rental housing and real estate in Québec has been lower when compared to other provinces like Ontario and British Columbia. It should be noted however, that in 2023, Québec witnessed the highest average yearly rent increase in 30 years, and the property vacancy rate was the lowest it has been in 20 years.[136] Thus, while core housing needs are reportedly higher elsewhere, Québecers are feeling the impacts of the national housing crisis. Furthermore, Indigenous peoples in the province experience disproportionate levels of inadequate housing. Almost 16% of Métis in Trois-Rivières and 27% of the Nunavik population in northern Québec live in housing needing major repairs and 47% of the Nunavik population live in crowded housing.[137]

The rate of poverty in Québec is lower than the national average. The number of Canadians experiencing poverty is 8.1%, while 6.4% of Québecers live in poverty. The lower rate of poverty is associated with the lower cost of living in the province, as well as progressive social policies, like subsidized childcare that has reduced women's poverty rate and increased their participation in the workforce.[138]

STIGMA AND DISCRIMINATION

The percentage of Québecers who report poor-to-fair mental health and who experience discrimination and victimization is one of the lowest in Canada, 5.6% compared to 9.1% nationally. This population reports a slightly lower sense of feeling connected to community compared to the national average (53.7% vs. 54.4%). The rates of arrest for people who use drugs in Québec are slightly higher than the national average, 167 vs. 162/100,000, which may indicate that the criminalization of and discrimination against people who use drugs is a concern in the province.

IN FOCUS >

Mental health in NEW BRUNSWICK

Population: 850,894 | Rural: 49.1%

New Brunswick is busy working to implement its mental health, addictions and substance use health (MHASU) strategy, which includes investing in e-mental health services, youth wellness hubs and better access to psychiatrists. This is welcome news given the province's lower rates of mental well-being and higher rates of mood, anxiety and substance use disorders compared to the Canadian averages. It also has the fewest psychiatrists in the country and lower rates of access to mental health services for children and youth.

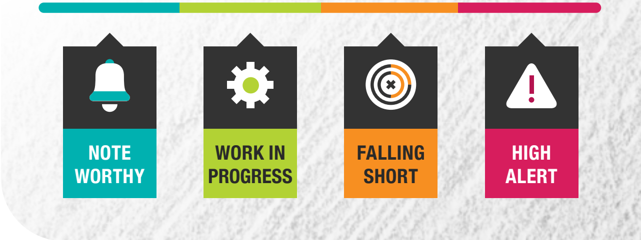
New Brunswickers report having a stronger sense of belonging to community and those with poorer mental health report lower rates of stigma and discrimination than in the rest of Canada. However, concerns about rights loom in the absence of a Mental Health Advocate, the introduction of regressive policies around gender identity in schools, and a pending bill on involuntary treatment for people with substance use problems.

IN FOCUS: NEW BRUNSWICK

	Indicator	Indicator Category	NB	CAN
1.1a	Mental health, addictions, and substance use (MHASU) Healthcare Investments	Policy	6%	6.3%
1.1b	Bilateral Health Spending for MHASU	Policy	14.8%	31%
1.2	MHASU Strategy	Policy	Moderately comprehensive	Out of date
1.3	Decriminalization policy	Policy	–	Low support
1.4	Harm reduction policy	Policy	Moderate support	High support
1.5	Mental Health Acts	Policy	High concern	–
2.1	Perceived mental health – poor/fair	Population Mental Health (MH)	27.9%	26.1%
2.2a	Prevalence of mood/anxiety disorders (12-month)	Population MH	14.5%	10.6%
2.2b	Prevalence of substance use disorders (lifetime)	Population MH	27.9%	20.7%
2.3	Rate of death by suicide	Population MH	11.8	10.9
2.4	Rate of hospitalization for self-harm	Population MH	59.3	64.9
2.5	Rate of apparent opioid toxicity deaths	Population MH	8.6	20.8
2.6	Rate of hospitalizations caused entirely by alcohol	Population MH	142	262
3.1	Percentage of population needing mental health care but needs are unmet or partially met	Service access	6.3%	7.8%
3.2	Percentage of youth with early MHASU service needs who accessed Community Mental Health services	Service access	45%	61%
3.3	Number of psychiatrists per 100,000 population	Service access	6.6	13.1
3.4	Supply of MHASU healthcare providers	Service access	2,067.5	1,721.4
3.5	30-day hospital readmission rates for MHASU concerns	Service access	12.2%	13.4%
4.1	Percentage of population reporting poor-to-fair mental health in core housing need	Social Determinants of Health (SDOH)	13.4%	15.8%
4.2	Poverty rate	SDOH	8.1%	8.1%
4.3	Employment rate for individuals with mental health disabilities (ages 25-64)	SDOH	44%	46.1%
5.1	Percentage of those with poor-to-fair mental health who experienced discrimination and victimization	Stigma and discrim	7.1%	9.1%
5.2	Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community	Stigma and discrim	55.9%	54.4%
5.3	Reported rate of drug-related offences	Stigma and discrim	158	162

Note: Values in the table above that do not have a percentage indicate a rate per 100,000 population

IN FOCUS: NEW BRUNSWICK



POLICY

Funding

In 2024-25, New Brunswick will spend approximately $232 million on mental health, which amounts to 6% of its overall health budget.[139] Through the Shared Health Priorities agreement struck between New Brunswick and the Government of Canada, funds dedicated to mental health, addictions and substance use (MHASU) between 2023-2026 amount to $46.2 million, which is only 14.8% of the total share of funding, falling far below national average spending of 31%.[140]

Strategy

New Brunswick released a MHASU strategy in 2021 with clear objectives, including reduced wait times for services (especially e-mental health), access to MHASU supports for those who are incarcerated, and better access to psychiatry, particularly for youth. The strategy also has a built-in accountability framework, although it remains unclear how the government will monitor progress. No funding was attributed to key areas in the strategy itself, although the government has noted that its 2020-2021 budget included investments in this strategy.[141]

Policy response to the toxic drug crisis

After a spike in 2022, the number of deaths attributed to drug toxicity has fortunately been trending downwards. The New Brunswick government has introduced some moderate policy measures to address the drug toxicity crisis. The addiction and mental health plan released in 2021 included the "implementation of overdose prevention sites" as a key priority initiative, and the first site opened in Moncton that same year. The New Brunswick Government does not provide any information on whether it supports drug checking or safer supply initiatives. Advocates have been calling for a second overdose prevention site in the province to address the need in Saint John.

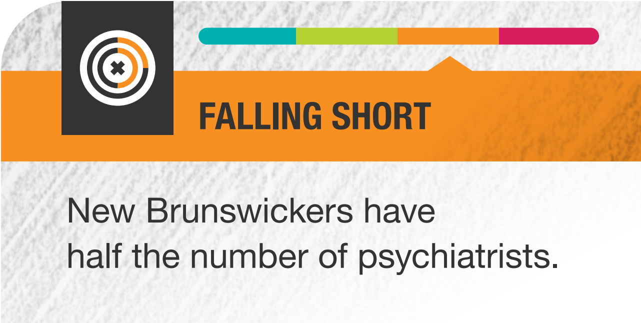
POPULATION MENTAL HEALTH

New Brunswick reports the highest rate of substance use disorders (SUDs) in the country (27.9%) and the second highest combined rate of mood and anxiety disorders (14.5%), after Saskatchewan. These rates are higher than the Canadian averages, which are 20.7% for SUDs and 10.6% for mood and anxiety disorders (combined rate).

The rate of apparent toxicity deaths due to opioids is about half of the national average (8.6 vs. 20.8/100,000). The rate has been on the rise since 2018, peaked during the pandemic and declined modestly in 2023.[142] However, New Brunswick reports the lowest rate of hospitalizations due to alcohol in the country (142 per 100,000 vs. 262 per 100,000).

Service Access

Based on the indicators selected for this report, service access in New Brunswick is lower than the Canadian average, signaling a critical need for attention. The number of psychiatrists in the province is half the Canadian average, with only 6.6 psychiatrists/ 100,000 people compared to 13.1/100,000 nationally.



New Brunswickers have half the number of psychiatrists.

IN FOCUS: NEW BRUNSWICK

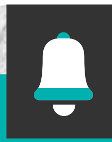
The challenges of accessing mental health care are particularly acute for New Brunswick youth. The data indicate only 45% of youth with MHASU healthcare needs were able to access community health services. At the same time, a New Brunswick Health Council survey in 2022 found that the percentage of youth in grades 6 to 12 who report depression or anxiety increased dramatically from 39.5% to 55.8%.[143] To address these concerns, the New Brunswick government plans to open six integrated youth wellness hubs where young people between the ages of 12 and 24 years can access mental health and substance use supports as well as other services.[144]

WORK IN PROGRESS

Plans to open six wellness hubs to address youth depression and anxiety

Accessing services in French, an official language in New Brunswick, remains a challenge.[145] New Brunswick also has the second highest rate of disability in Canada but has limited resources to meet the needs of people with disabilities.[146]

To improve access to mental health services and supports, New Brunswick implemented the Stepped Care 2.0 model in 2022, which has been credited with improving access to same-day, rapid-access support. Further efforts are needed to improve access to longer-term, specialized treatment by psychiatrists or psychologists.[147]



NOTEWORTHY

Same-day, rapid-access mental health, addictions and substance use (MHASU) care are part of provincial strategy.

SOCIAL DETERMINANTS OF HEALTH

The poverty rate in New Brunswick is the same as the national rate and fewer New Brunswick residents report a core housing need (13.4%) than the average (15.8%). The employment rate for individuals with mental health-related disabilities, however, is slightly below the national average: 44% compared to 46.1%.

STIGMA AND DISCRIMINATION

When it comes to reported rates of discrimination and mistreatment and sense of belonging to community, New Brunswick reports some of the country's most favourable rates. Of those reporting poor-to-fair mental health, 7.1% say they experienced stigma or discrimination compared to the Canadian average of 9.1%. More people in New Brunswick (55.9%) report a stronger sense of belonging to community than average (54.4%).

Despite these favourable rates, significant human rights concerns have been raised within the province. The New Brunswick government announced its intent to introduce the "Compassionate Intervention Act," legislation similar to the one proposed in Alberta that would allow involuntary detention and treatment for people on the grounds of substance use problems or an addiction.[148]

This legislation is concerning given the lack of evidence to support forced treatment for addictions. Research shows that coercive treatment not only undermines the health and well-being of those who use substances, but it can also be fatal.[149]

HIGH ALERT

Pending involuntary treatment for substance use or addiction without evidence to support it

In addition, the Government of New Brunswick recently made changes to policy 713, the Sexual Orientation and Gender Identity policy, that puts parental consent rights before the rights of children in their expression of gender identity in schools, a move that has been criticized as an attack on the rights of transgender and non-binary children and communities in New Brunswick.[150]

The rate of police-reported crime for drug offences in New Brunswick is lower than the Canadian average: 152 compared to Canada's 168 per 100,000.

IN FOCUS >

Mental health in NOVA SCOTIA

Population: 1,072,545 | **Rural:** 41.1%

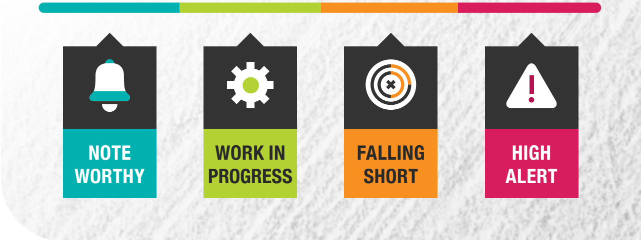
Nova Scotia's mental health system is undergoing a significant transformation, as the government prepares to launch its Universal Mental Healthcare program with access to free psychotherapy—a first for Canada. Nova Scotia performs well on access to services overall but reports longer wait times and a lower performance on the population mental health indicators compared to the Canadian average.

The challenges that lie ahead for the province include ensuring adequate funding for services, a commitment to strengthening the policy framework for harm reduction, and a focus on housing and income supports to address the above-average rates of poverty and core housing need that compromise the mental health of its people.

IN FOCUS: NOVA SCOTIA

Indicator		Indicator Category	NS	CAN
1.1a	Mental health, addictions, and substance use (MHASU) Healthcare Investments	Policy	4.9%	6.3%
1.1b	Bilateral Health Spending for MHASU	Policy	16.3%	31%
1.2	MHASU Strategy	Policy	Out of date	Out of date
1.3	Decriminalization policy	Policy	–	Low support
1.4	Harm reduction policy	Policy	Moderate support	High support
1.5	Mental Health Acts	Policy	Ins.	–
2.1	Perceived mental health – poor/fair	Population Mental Health (MH)	28.8%	26.1%
2.2a	Prevalence of mood/anxiety disorders (12-month)	Population MH	13.9%	10.6%
2.2b	Prevalence of substance use disorders (lifetime)	Population MH	23.8%	20.7%
2.3	Rate of death by suicide	Population MH	11.0	10.9
2.4	Rate of hospitalization for self-harm	Population MH	43.2	64.9
2.5	Rate of apparent opioid toxicity deaths	Population MH	7.0	20.8
2.6	Rate of hospitalizations caused entirely by alcohol	Population MH	280	262
3.1	Percentage of population needing mental health care but needs are unmet or partially met	Service access	7.8%	7.8%
3.2	Percentage of youth with early MHASU service needs who accessed Community Mental Health services	Service access	72%	61%
3.3	Number of psychiatrists per 100,000 population	Service access	14.5	13.1
3.4	Supply of MHASU healthcare providers	Service access	2,224.9	1,721.4
3.5	30-day hospital readmission rates for MHASU concerns	Service access	10.3%	13.4%
4.1	Percentage of population reporting poor-to-fair mental health in core housing need	Social Determinants of Health (SDOH)	16.9%	15.8%
4.2	Poverty rate	SDOH	9.8%	8.1%
4.3	Employment rate for individuals with mental health disabilities (ages 25-64)	SDOH	44%	46.1%
5.1	Percentage of those with poor-to-fair mental health who experienced discrimination and victimization	Stigma and discrim	7.1%	9.1%
5.2	Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community	Stigma and discrim	55.9%	54.4%
5.3	Reported rate of drug-related offences	Stigma and discrim	96	162

Note: Values in the table above that do not have a percentage indicate a rate per 100,000 population



POLICY

Funding

Nova Scotia is set to become a trailblazer in mental health, addictions and substance use health (MHASU) service delivery: in 2021, it became the first province to commit to offering universal coverage for mental health services, including free psychotherapy and same-day support. Last year, the Government of Nova Scotia introduced Bill 334, an amendment to the *Health Services and Insurance Act* that would allow for public funding for services offered by psychotherapists, social workers and registered counseling therapists. This free service is currently in a pilot phase and is set to launch between 2024 and 2025.[151] This policy is still in early stages of implementation and so far, government has opted to roll out the public delivery of these mental health services using private service providers.

Despite this unprecedented commitment to universal access, Nova Scotia spends a comparatively smaller amount on mental health. The 2024-2025 Budget commits $359.6 million for MHASU, which amounts to $371 per capita, or 4.9% of the overall health budget. With the cost of the new universal mental healthcare counseling program estimated at $100 million a year, the Nova Scotia government is leaning on the new 2023 Canada-Nova Scotia *Working Together Agreement* (2023 Bilateral deal) to help fund the pilot phase.[152] As per the 2023 Bilateral Agreement and the remaining funds from the 2017 Bilateral Agreement between Canada and Nova Scotia, the province is earmarking $19.3 million dollars for mental health and addictions from 2023-2026. This spending is also on the lower end, representing 16.3% of the overall health spending of the Bilateral agreements compared to the Canadian average of 31%.[153]

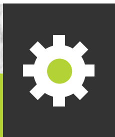
Strategy

Nova Scotia does not have a dedicated mental health, addictions and substance use (MHASU) strategy. The province's plans for MHASU health care are integrated into its general healthcare strategy, outlined in the 2022-2026 *Action for Health Strategic Plan*, but this plan does not contain many details about how it plans to build and strengthen the MHASU infrastructure and lacks both a timeline and performance measurement framework. The plan states that the goals are to reduce gaps in service access through investments in harm reduction programs, establish universal mental health and addictions coverage, and facilitate access to same-day mental health support, among other initiatives.[154] Nova Scotia has an *Opioid Use and Overdose Framework*, first published in 2017, and it has produced a progress update on completed actions every year since.

Policy response to the toxic drug crisis

The Nova Scotia Government provides limited support for harm reduction. Like all other provinces, Nova Scotia funds a Take Home Naloxone Program and several needle exchange programs. It has provided financial support to the province's two

overdose prevention sites, ReFix and Peer Six. It does not fund drug checking or safer supply programs and these harm reduction initiatives were not included in the province's *Action for Health Strategic Plan*.[155] However, the Nova Scotia Government funds the Mobile Outreach Street Health Unit (MOSH), which provides outreach services and has two staff physicians that prescribe safer supply.[156]



WORK IN PROGRESS

Government is funding two overdose prevention sites and a mobile outreach service, but more supports for harm reduction are needed.

POPULATION MENTAL HEALTH

Nova Scotians report poorer mental health than the Canadian average. Those who perceive their mental health to be poor or fair is 28.8%, compared to 26.1% nationally. The rates of mood/anxiety disorders (13.9%), substance use disorders (23.8%), and hospitalizations due to alcohol (280 per 100,000) are higher than the national average.

Although Nova Scotia's rate of apparent opioid-related deaths is less than one-third the national rate (7/100,000 compared to 20.8/100,000), it has been trending upwards. In fact, the longitudinal trend for the province diverges from the rest of Canada in that the rate of death *decreased* during the pandemic and showed a sharp increase in 2022 and 2023, bringing the number of deaths from 40 in 2021 to 74 in 2023.

Where Nova Scotia performs better than the Canadian average is in the rate of hospitalization due to self-harm, at 42.3 cases per 100,000 compared to 64.9 nationally.

ACCESS TO SERVICES

At face value, the data suggest that Nova Scotia exceeds national averages when it comes to MHASU service access. Seventy-two percent of youth in Nova Scotia experiencing mental health or substance use healthcare needs are accessing care, a rate which is 11% higher than the national average. The 30-day hospital readmission rate for those with a MHASU concern is lower than average. Nova Scotia also has a higher distribution of psychiatrists (14.5 compared to 13.1 in Canada) as well as one of the highest numbers of MHASU healthcare providers per 100,000 population (2,224.9/100,000 vs. 1,721.4/100,000 in Canada.)

FALLING SHORT

High urban concentration of psychiatrists but rural Nova Scotians have poor access to mental health services

The wait times for services, however, tell a different story. Nova Scotia Health reports up-to-date information on its website about wait times and, depending on the region, they can range from 0 days to 195 days for non-urgent care, and between 0-13 days for urgent care.[157] Furthermore, there are increased barriers to accessing services in rural areas of Nova Scotia. Psychiatric services and Rapid Access Addiction Medicine (RAAM) clinics, for example, are concentrated in urban areas, requiring rural Nova Scotians to travel long distances to access them.[158] Nova Scotia Health and Dalhousie University recently partnered to reduce wait times to a few weeks through the rapid access and stabilization program for improving access to mental health services.[159]

SOCIAL DETERMINANTS OF HEALTH

Nova Scotia's poverty rate and core housing need are concerning. At 9.8%, the poverty rate is the highest in Canada and will likely rise again as pandemic-era financial supports have ended.[160] Nova Scotians also report a higher core housing need (16.9%) than the national average (15.8%). When the data is disaggregated by race, findings show that Black Nova Scotians have lower income levels and higher core housing need, which is roughly double that of other Nova Scotians.[161] Nova Scotia also reports a slightly lower employment rate for people with MHASU disabilities: 44% compared to the 46.1% average.

STIGMA AND DISCRIMINATION

Nova Scotia performs well overall on the indicators in the stigma and discrimination category. Fewer Nova Scotians with poor-to-fair mental health report victimization or discrimination (7.1% vs. the average of 9.1%) and 55.9% report a sense of feeling connected to community, which is slightly higher than the national average of 54.9%. The province also reports a much lower rate of police-reported crime for drug offences (96/100, 000 vs. 162/100,000 nationally).

HIGH ALERT

Black Nova Scotians experience higher rates of poverty and inadequate housing.

IN FOCUS >

Mental health in PRINCE EDWARD ISLAND

Population: 177,081

Rural population: 54%

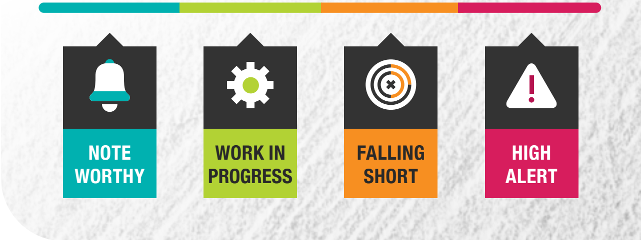
Spending for mental health, addictions and substance use (MHASU) health care on PEI is higher than average, but with a shortage of psychiatrists and in-patient beds, getting care is difficult. PEI's mental health strategy, in place since 2016, produced a workforce strategy and led to the creation of a mobile crisis unit and a new Emergency Department specializing in mental health and addictions. The strategy itself, however, is vague on targeted investments and measurement. The suicide rate on PEI is lower than in the rest of the country and Islanders fare better in terms of their overall well-being and report lower unmet needs. However, the rates of self-harm are higher. Drug-related crime is low, and drug toxicity deaths are a fraction of the Canadian rate. Still, the government is taking steps to reduce drug-related harms, but in so doing, has encountered some community resistance. This suggests work is needed to address stigma and discrimination so that people who use drugs in PEI can get the services they need.

IN FOCUS: PRINCE EDWARD ISLAND

	Indicator	Indicator Category	PEI	CAN
1.1a	Mental health, addictions, and substance use (MHASU) Healthcare Investments	Policy	6.9%	6.3%
1.1b	Bilateral Health Spending for MHASU	Policy	8.3%	31%
1.2	MHASU Strategy	Policy	Somewhat comprehensive	out of date
1.3	Decriminalization policy	Policy	–	low support
1.4	Harm reduction policy	Policy	Moderate support	High support
1.5	Mental Health Acts	Policy	Low concern	–
2.1	Perceived mental health – poor/fair	Population Mental Health (MH)	18.3%	26.1%
2.2a	Prevalence of mood/anxiety disorders (12-month)	Population MH	–	10.6%
2.2b	Prevalence of substance use disorders (lifetime)	Population MH	–	20.7%
2.3	Rate of death by suicide	Population MH	4.1	10.9
2.4	Rate of hospitalization for self-harm	Population MH	78.6	64.9
2.5	Rate of apparent opioid toxicity deaths	Population MH	4	20.8
2.6	Rate of hospitalizations caused entirely by alcohol	Population MH	248	262
3.1	Percentage of population needing mental health care but needs are unmet or partially met	Service access	6.7%	7.8%
3.2	Percentage of youth with early MHASU service needs who accessed Community Mental Health services	Service access	–	61%
3.3	Number of psychiatrists per 100,000 population	Service access	5.2	13.1
3.4	Supply of MHASU healthcare providers	Service access	1,957.5	1,721.4
3.5	30-day hospital readmission rates for MHASU concerns	Service access	12.1%	13.4%
4.1	Percentage of population reporting poor-to-fair mental health in core housing need	Social Determinants of Health (SDOH)	9.7%	15.8%
4.2	Poverty rate	SDOH	8.7%	8.1%
4.3	Employment rate for individuals with mental health disabilities (ages 25-64)	SDOH	49.9%	46.1%
5.1	Percentage of those with poor-to-fair mental health who experienced discrimination and victimization	Stigma and discrim	7.1%	9.1%
5.2	Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community	Stigma and discrim	54.4%	54.4%
5.3	Reported rate of drug-related offences	Stigma and discrim	76	162

Note: Values in the table above that do not have a percentage indicate a rate per 100,000 population

IN FOCUS: PRINCE EDWARD ISLAND



POLICY

Funding

PEI's spending on mental health is higher than average. The province allocated $77 million for mental health in its 2024-2025 budget, which amounts to 6.9% of the overall health budget. Disappointingly, the new *Working Together Agreement* struck between PEI and the Government of Canada in 2023 does not include any funding for MHASU, but $7.8 million in remaining funds from the 2017 Bilateral Agreement was agreed to be spent for 2023-2026, which means that only 8.3% of the total Bilateral funding will go to mental health, addictions and substance use (MHASU) care. This makes PEI the lowest spender of bilateral funding for mental health among all the provinces and territories.[162]

Strategy

PEI has a mental health strategy, *Moving Forward Together—Prince Edward Island's Mental Health and Addiction Strategy*, which spans 10 years (2016-2026). The strategy identifies five strategic priorities for investment as well as challenges and opportunities for each, but it does not identify targeted programs or services for investment, a timeline of actions or how it plans to measure progress.

Mental Health Act

Last year, PEI updated its *Mental Health Act* to include community treatment orders. Data on the approximate number of complaints related to involuntary treatment was not available.

Policy Response to the Toxic Drug Crisis

The PEI government recognizes that there are considerable health impacts and loss of life associated with the toxic drug supply and it is currently working to enact policies to support harm reduction. In 2023, it announced plans for the province's first Overdose Prevention Site in Charlottetown, although the site has not yet been established because it was rejected by the Charlottetown municipal council.[163] The PEI government is also funding capital costs for drug checking, including an infrared spectrometer (FTIR) at one harm reduction organization in Charlottetown and fentanyl test strips at 10 locations across the province. The PEI government also supports a province-wide Needle Exchange Program and Take Home Naloxone Program.[164]

WORK IN PROGRESS

PEI's plans for the first Overdose Prevention Site in Charlottetown have stalled due to municipal opposition.

POPULATION MENTAL HEALTH

The suicide rate on PEI is much lower than the national average at 4.1/100,000 people compared to 10.9/100,000 nationally. Similarly, Islanders self-report their mental health more positively than in the rest of Canada. Only 18.3% of Islanders rated their mental health as poor-to-fair compared to 26.1% nationally. It is important to note, however, that certain populations on the island report greater mental health problems. For example, PEI farmers report depression and anxiety levels that are much higher than the general population.[165]

The drug toxicity crisis has not been felt as deeply on PEI as in other parts of Canada: the number of apparent opioid toxicity deaths are lower, about one-sixth of the national average (4/100,000 compared to 20.8/100,000). However, the rates peaked recently during the pandemic, at 7.4 apparent opioid toxicity deaths per 100,000.

SERVICE ACCESS

Although some of the indicators of service access for PEI perform above the Canadian average, others suggest there are barriers. Fewer Islanders needing MHASU care, compared to the rest of Canada, report that they had an unmet need for services (6.7% vs. 7.8%) and the rate of readmission to hospital for a MHASU concern is slightly lower than what is reported nationally (12.1% versus 13.4%). However, there are workforce capacity problems in the province: there are only 5.2 psychiatrists per 100,000 population in PEI (8 in total), less than half of the national average (13.1/100,000).

FALLING SHORT

Difficult to get care with only 8 psychiatrists on the Island

The smaller MHASU workforce and the shortage of inpatient spaces have been identified as important barriers to services in PEI. As in other Atlantic provinces, Prince Edward Islanders who live in rural parts of the Island have problems accessing mental health services, which are concentrated in urban centres.[166]

In response, the government announced its intention to create a workforce development strategy[167] and, last year, it launched a mobile crisis unit to relieve pressure on the acute care system. More recently, a new Emergency Department specializing in mental health and addictions has opened and will provide 24/7 urgent care and clinical support for people with mental health and substance use problems.[168]

NOTEWORTHY

New mobile crisis unit and Emergency Department with 24/7 urgent care

SOCIAL DETERMINANTS OF HEALTH

The core housing need in PEI is about half that of the national average (8.7% vs. 15.8%). However, the cost-of-living crisis has also impacted Prince Edward Island. The poverty rate on the island is slightly higher than the national average (8.7% vs. 8.1%), but, notably, in 2022, PEI was the most food insecure province in Canada.[169] The percentage of people unable to afford nutritious food rose from 17.3% in 2019 to 23.6% in 2022. Moreover, in 2022, 35.1% of children in PEI lived in food-insecure households. Given the links between poverty, food security, and mental health, these concerning trends must be addressed.

HIGH ALERT

More than one third of children live in households that don't have enough food.

STIGMA AND DISCRIMINATION

Prince Edward Islanders who report poor-to-fair mental health also report less victimization and discrimination than Canadians on average (7.1% compared to 9.1%) and feel a sense of community at percentages on par with the rest of the country. However, the rate of police-reported crime for drug offences in PEI is much lower than the national average: 76 compared to 162/100,000. While this lower rate indicates that Islanders are less likely to be criminalized for possessing and using unregulated drugs, community resistance to establishing overdose prevention services also suggests that considerable work needs to be done in PEI to address the stigma attached to substance use health services and those who need them.

IN FOCUS >

Mental health in NEWFOUNDLAND AND LABRADOR

Population: 541,391

Rural: 40%

As one of Canada's most rural provinces, Newfoundland and Labrador struggles to retain its mental health workforce and provide good access to services, even though the indicators perform better overall than the Canadian average. The province reports the lowest rates of mood, anxiety and substance use disorders and the lowest rate of unmet need for services. At the same time, Newfoundland and Labrador has the highest self-reported rate of poor mental health in Canada as well as the highest rate of hospitalizations for self-harm among the provinces. Access to psychiatrists is a challenge, as are wait times for services, but a new single-session, rapid-access service may help address waits.

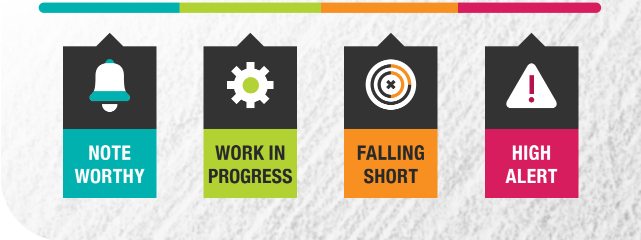
Newfoundland and Labrador's previous mental health strategy, which is now out of date, produced important new policies, including action plans on alcohol and suicide prevention, as well as an updated Mental Health Act. However, the province needs a new mental health strategy to provide a clear path for the next decade of mental health policy, along with a harm reduction strategy in light of the rising number of deaths due to opioids and stimulants.

IN FOCUS: NEWFOUNDLAND AND LABRADOR

Indicator		Indicator Category	NL	CAN
1.1a	Mental health, addictions, and substance use (MHASU) Healthcare Investments	Policy	Ins.	6.3%
1.1b	Bilateral Health Spending for MHASU	Policy	19.1%	31%
1.2	MHASU Strategy	Policy	Out of date	Out of date
1.3	Decriminalization policy	Policy	–	Low support
1.4	Harm reduction policy	Policy	Moderate support	High support
1.5	Mental Health Acts	Policy	Low concern	–
2.1	Perceived mental health – poor/fair	Population Mental Health (MH)	30%	26.1%
2.2a	Prevalence of mood/anxiety disorders (12-month)	Population MH	8.7%	10.6%
2.2b	Prevalence of substance use disorders (lifetime)	Population MH	14.9%	20.7%
2.3	Rate of death by suicide	Population MH	10.9	10.9
2.4	Rate of hospitalization for self-harm	Population MH	94.2	64.9
2.5	Rate of apparent opioid toxicity deaths	Population MH	6.7	20.8
2.6	Rate of hospitalizations caused entirely by alcohol	Population MH	187	262
3.1	Percentage of population needing mental health care but needs are unmet or partially met	Service access	6.0%	7.8%
3.2	Percentage of youth with early MHASU service needs who accessed Community Mental Health services	Service access	–	61%
3.3	Number of psychiatrists per 100,000 population	Service access	11.6	13.1
3.4	Supply of MHASU healthcare providers	Service access	2,203.6	1,721.4
3.5	30-day hospital readmission rates for MHASU concerns	Service access	12.6%	13.4%
4.1	Percentage of population reporting poor-to-fair mental health in core housing need	Social Determinants of Health (SDOH)	16.8%	15.8%
4.2	Poverty rate	SDOH	8.2%	8.1%
4.3	Employment rate for individuals with mental health disabilities (ages 25-64)	SDOH	40.9%	46.1%
5.1	Percentage of those with poor-to-fair mental health who experienced discrimination and victimization	Stigma and discrim	7.1%	9.1%
5.2	Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community	Stigma and discrim	54.6%	54.4%
5.3	Reported rate of drug-related offences	Stigma and discrim	171	162

Note: Values in the table above that do not have a percentage indicate a rate per 100,000 population

IN FOCUS: NEWFOUNDLAND AND LABRADOR



POLICY

Funding

Assessing the strength of Newfoundland and Labrador's mental health, addictions and substance use (MHASU) healthcare policy is challenging: the details regarding funding and long-term plans for MHASU care aren't clear. In this year's budget (2024-2025), NL announced an unprecedented $4.1 billion in spending for health care, but it contained no estimates for MHASU. What we do know is that the funding for the new Shared Health Priorities agreement struck between the province and Government of Canada (2023) falls below average spending across Canada. Between 2023-2026, $24.65 million will go to Assertive Community Treatment, rural and remote MHASU, a new mental health facility and community mental health, and the $24.3 million left over from the 2017 Bilateral Agreement Action Plan will also be spent.[170] This amounts to $48.95 million, or 19.1% of the overall Bilateral agreement spending, which is lower than average (31%).

Strategy

Newfoundland and Labrador's mental health strategy is now out of date. In 2017, the province released a 5-year mental health action plan, *Towards Recovery: The Mental Health and Addictions Action Plan*.

Although all 54 recommendations in this action plan are reported as 'substantially complete,'[171] no specific performance measurement indicators or funding commitments are outlined.[172] In June 2022, the provincial government published an action plan to reduce suicide rates and a Provincial Alcohol Action Plan.

Mental Health Act

The *Mental Health Care and Treatment Act* was updated in 2022 and has a mandatory review for a quality improvement process every five years. In this review process, there is a provincial quality assurance review regarding issuance, administration, monitoring and oversight of community treatment orders (CTOs).[173]

Policy response to drug toxicity crisis

Support for harm reduction policy is low in Newfoundland and Labrador: there are no supervised consumption or overdose prevention services in the province, despite calls from advocacy groups to establish them.[174] Last year, the government struck an all-party committee to develop recommendations on how to support people who use drugs, but proposed actions have not yet been announced.[175]

POPULATION MENTAL HEALTH

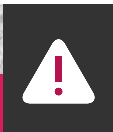
Newfoundland and Labrador reports the lowest prevalence of mood (8.3%), anxiety (9%), and substance use disorders (14.9%) in all of Canada, but also the highest rates of poor mental health (30% compared to 26.1%). It also reports the highest rate of self-harm among the provinces, at a rate of 94.2 per 100,000.

The suicide rate in Newfoundland and Labrador matches the national rate of 10.9/100,000 people. However, suicide rates in the province vary significantly based on demographic and geographic characteristics. From 2020-2021, the Labrador-Grenfell Health region, for instance, had double the suicides compared to the province at large, and Inuit and Innu persons are disproportionately represented among the province's suicides.[176] From 1993 to 2009, the rate of suicide among Labrador's Innu was found to be 10 to 15 times higher than that of the non-Indigenous population of the province.[177]

Amidst the nationwide drug toxicity crisis, Newfoundland and Labrador reports a much lower rate of death from opioid toxicity. The province's incidence rate is 6.7 deaths/100,000 people, less than a third of the national average (20.8 deaths/100,000). However, the number of deaths in the province has been climbing.

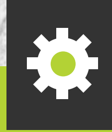
SERVICE ACCESS

Overall, the service access data in this report are more favourable for Newfoundland and Labrador. The province reports a lower rate of unmet need among those with mental health concerns (6%) compared to the Canadian average (7.8%) and a lower rate of readmission to hospital for MHASU health reasons. The MHASU workforce is also above average (2,203.6 per 100,000 people). The only service access indicator that underperforms is the number of psychiatrists per 100,000, reported to be 11.6, slightly below the national rate of 13.1 /100,000. However, reports from Newfoundland and Labrador tell a different story about access. In 2017, the province launched the 'Stepped Care 2.0' approach to reduce wait times, but psychologists from the Association of Psychology in Newfoundland and Labrador have noted that this approach has improved access to single-session, low-intensity forms of mental health support, but has not had positive impacts on wait times for specialized, higher intensity mental health treatment, usually provided by psychologists and psychiatrists.[178] More recently, Newfoundland and Labrador's Psychology Board reported that the province has some of the longest wait times in Canada for mental health services and that psychologists are moving out of the public system into private practice, causing a shortage.[179]



HIGH ALERT

NL reports the highest rate of self-harm among the provinces.



WORK IN PROGRESS

Single-session, rapid access supports have reduced wait times, but not for treatment by specialists.

SOCIAL DETERMINANTS OF HEALTH

The core housing need for residents reporting poor-to-fair mental health is slightly higher than the average, at 16.8% compared to 15.8% and the poverty rate in Newfoundland is close to average. However, the employment rate for people with mental health-related disabilities is below the national average, 40.9% compared to 46.1%.

STIGMA AND DISCRIMINATION

The rates of stigma and discrimination experienced by those who report poor-to-fair mental health are lower for Newfoundland and Labrador, just as for the whole Atlantic region. However, Newfoundland and Labrador reports a higher-than-average rate of police-reported drug offences (171 compared to 162 /100,000), which suggests more work is needed to support the health needs of people who use drugs.

IN FOCUS >

Mental health in YUKON

Population: 45,750

Rural: 36.4%

Of all provinces and territories, Yukon is dedicating the largest share of current Federal Bilateral health funding to mental health. This healthy investment complements wellness and substance use strategies to address some of the country's highest rates of self-harm and apparent opioid toxicity deaths. The hospitalizations due to alcohol are also four times the national average. In response, the Yukon government has introduced some important harm reduction measures, including the only supervised consumption site in the territories, a managed alcohol program and land-based healing programs.

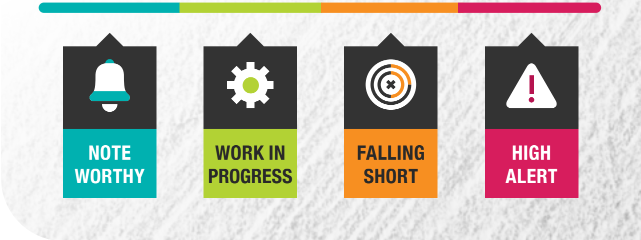
It has also created successful—but perhaps under-resourced—mental wellness and substance use 'hubs' in rural parts of the territory. On the urban front, however, an inadequate government housing response means homelessness has skyrocketed in Whitehorse, the largest city.

IN FOCUS: YUKON

	Indicator	Indicator Category	YK	CAN
1.1a	Mental health, addictions, and substance use (MHASU) Healthcare Investments	Policy	6.4%	6.3%
1.1b	Bilateral Health Spending for MHASU	Policy	77%	31%
1.2	MHASU Strategy	Policy	Moderately comprehensive	Out of date
1.3	Decriminalization policy	Policy	–	Low support
1.4	Harm reduction policy	Policy	High support	High support
1.5	Mental Health Acts	Policy	Ins.	–
2.1	Perceived mental health – poor/fair	Population Mental Health (MH)	23.3%	26.1%
2.2a	Prevalence of mood/anxiety disorders (12-month)	Population MH	–	10.6%
2.2b	Prevalence of substance use disorders (lifetime)	Population MH	–	20.7%
2.3	Rate of death by suicide	Population MH	–	10.9
2.4	Rate of hospitalization for self-harm	Population MH	204.8	64.9
2.5	Rate of apparent opioid toxicity deaths	Population MH	37.8	20.8
2.6	Rate of hospitalizations caused entirely by alcohol	Population MH	948	262
3.1	Percentage of population needing mental health care but needs are unmet or partially met	Service access	–	7.8%
3.2	Percentage of youth with early MHASU service needs who accessed Community Mental Health services	Service access	–	61%
3.3	Number of psychiatrists per 100,000 population	Service access	3.2	13.1
3.4	Supply of MHASU healthcare providers	Service access	2,205.2	1,721.4
3.5	30-day hospital readmission rates for MHASU concerns	Service access	15.1%	13.4%
4.1	Percentage of population reporting poor-to-fair mental health in core housing need	Social Determinants of Health (SDOH)	–	15.8%
4.2	Poverty rate	SDOH	8.8%	8.1%
4.3	Employment rate for individuals with mental health disabilities (ages 25-64)	SDOH	64.9%	46.1%
5.1	Percentage of those with poor-to-fair mental health who experienced discrimination and victimization	Stigma and discrim	–	9.1%
5.2	Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community	Stigma and discrim	–	54.4%
5.3	Reported rate of drug-related offences	Stigma and discrim	633	162

Note: Values in the table above that do not have a percentage indicate a rate per 100,000 population

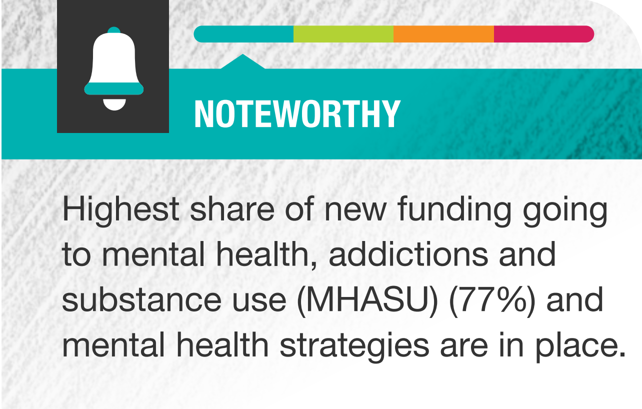
IN FOCUS: YUKON



POLICY

Funding

The Yukon government will be spending $43 million on mental health care in 2024-25, which amounts to 6.4% of the overall healthcare budget. Of all Canadian provinces and territories, Yukon is dedicating the highest share of the *Working Together Agreement* (2023 Bilateral Health Agreement) and the remaining *Shared Health Priorities* (2017) funding to mental health, addictions and substance use (MHASU) health care. Combined, this represents 77% of the bilateral funding.[180]



Strategy

Yukon has several mental health-related strategies in place, including the *Mental Wellness Strategy* (2016-2026), the *Substance Use Health Emergency Strategy* (2023) and the *Missing and Murdered Indigenous Women, Girls and Two-spirit+ People Strategy*.[181] In addition, in 2020, a team of independent reviewers commissioned by the Yukon government produced the *Putting People First report*, which made 76 recommendations to improve the health and social services systems. The Yukon government releases annual reports to provide progress updates on the recommendations.[182]

Policy Response to the toxic drug crisis

The Yukon government has introduced some important harm reduction measures to address the drug toxicity crisis. It is the only jurisdiction other than British Columbia to have declared a Substance Use Health Emergency (2022).[183] It is also one of the only jurisdictions to offer Narcan (nasal naloxone) in its publicly funded Take Home Naloxone (THN) Program and it funds the territories' only supervised consumption site, Blood Ties Four Directions, which also offers supervised inhalation services. The Yukon government also supports two safer supply programs and has been working with physicians to ensure they are trained in prescribing safer supply.[184]

POPULATION MENTAL HEALTH

Alarmingly, the territories report the highest rates of hospitalization for self-harm in Canada. The rates are 204.8/100,000 (102.4/50,000)[185] for Yukon versus the Canadian average 64.9/100,000.

Furthermore, Yukon reports greater than average harms due to substance use. Yukon has the third highest rate of apparent opioid toxicity deaths: the rate is 37.8 per 100,000, or 18.9 per 50,000 when adjusting for the territory's smaller population. First

Nations communities are disproportionately affected by the toxic drug crisis, representing two-thirds of deaths in Yukon in 2023.[186] Two First Nations communities in Yukon, Carcross Tagish and Na-Cho Nak Dun, have declared states of emergency after numerous drug-related overdoses and deaths.[187] The rate of hospitalizations due to alcohol is also extraordinarily high, at 948 per 100,000 (474 per 50,000) compared to the average, 262 per 100,000.

SERVICE ACCESS

The Yukon government has taken steps to increase access to mental health and substance use supports and services. To bolster service accessibility in rural areas of Yukon, the territorial health department has invested in four mental wellness and substance use 'hubs.' An Auditor General report found that these hubs were successful in increasing access to needed services but noted they were at times understaffed, lacked necessary resources and did not adequately serve First Nations clients.[188]

WORK IN PROGRESS

Successful wellness and substance use 'hubs' but inadequate service for First Nations clients

The Yukon government announced it would open a managed alcohol program in spring 2024 to improve health outcomes and reduce the number of hospitalizations and Emergency Department visits for alcohol poisonings.[189] Yukon also plans to invest almost $10 million in land-based healing programs over 2023-2026.[190]

SOCIAL DETERMINANTS OF HEALTH

No data are available for any of the territories for *Indicator 4.1, Core Housing Need* for people reporting poor-to-fair mental health. However, the housing need in the circumpolar north is critical, as shown by overall data for the general population (not specific to people with mental health needs) in the territories. In Yukon, the percentage of the general population with a core housing need was 13.2% in 2021.

Yukon is experiencing a severe housing crisis. In Whitehorse, Yukon's capital and largest city, rents and home prices have skyrocketed over the past 10 years. At the same time, the number of people who are underhoused and homeless in the city has climbed, as has the need for community housing.[191] A 2022 auditor general report found that, since 2010, the territorial housing corporation had not made significant progress in alleviating the housing shortage.[192]

FALLING SHORT

Homelessness has skyrocketed in Whitehorse, the largest city, amid poor government response.

STIGMA AND DISCRIMINATION

The high rate of police-reported drug offences in Yukon is a concern; at 633 per 100,000 (316.5 per 50,000), the rate is four times the national average (162 per 100,000). Yukon's rate suggests that there may be a higher rate of stigma and discrimination against people who use substances.

IN FOCUS >

Mental health in NORTHWEST TERRITORIES

Population: 44,741 | **Rural:** 34.7%

As one of the most sparsely populated regions in Canada, challenged by extreme weather and a limited health infrastructure, the Northwest Territories reports a greater prevalence of harm: self-harm and alcohol harm rates are among the highest in Canada, and, in remote and isolated communities, the suicide rates are double those in Yellowknife, the capital city. While data are incomplete, we can still get a good picture of access to services in NWT: the low supply of providers, and notably of psychiatrists, means that people have a very high 30-day hospital readmission rate.

The Northwest Territories spends a very small percentage (4%) of its healthcare budget on mental health, addictions and substance use (MHASU) health care and its mental health strategy is out of date, although it introduced its first alcohol strategy in 2023. The rate of police-reported drug offences is about four times the national average. In general, a lack of housing and housing affordability are critical in the Northwest Territories.

IN FOCUS: NORTHWEST TERRITORIES

Indicator		Indicator Category	NT	CAN
1.1a	Mental health, addictions, and substance use (MHASU) Healthcare Investments	Policy	4%	6.3%
1.1b	Bilateral Health Spending for MHASU	Policy	38.7%	31%
1.2	MHASU Strategy	Policy	Out of date	Out of date
1.3	Decriminalization policy	Policy	–	Low support
1.4	Harm reduction policy	Policy	Moderate support	High support
1.5	Mental Health Acts	Policy	Ins.	–
2.1	Perceived mental health – poor/fair	Population Mental Health (MH)	23.3%	26.1%
2.2a	Prevalence of mood/anxiety disorders (12-month)	Population MH	–	10.6%
2.2b	Prevalence of substance use disorders (lifetime)	Population MH	–	20.7%
2.3	Rate of death by suicide	Population MH	11.5	10.9
2.4	Rate of hospitalization for self-harm	Population MH	237.2	64.9
2.5	Rate of apparent opioid toxicity deaths	Population MH	4.4	20.8
2.6	Rate of hospitalizations caused entirely by alcohol	Population MH	1,412	262
3.1	Percentage of population needing mental health care but needs are unmet or partially met	Service access	–	7.8%
3.2	Percentage of youth with early MHASU service needs who accessed Community Mental Health services	Service access	–	61%
3.3	Number of psychiatrists per 100,000 population	Service access	3.2	13.1
3.4	Supply of MHASU healthcare providers	Service access	1,110.8	1,721.4
3.5	30-day hospital readmission rates for MHASU concerns	Service access	17.6%	13.4%
4.1	Percentage of population reporting poor-to-fair mental health in core housing need	Social Determinants of Health (SDOH)	–	15.8%
4.2	Poverty rate	SDOH	10.2%	8.1%
4.3	Employment rate for individuals with mental health disabilities (ages 25-64)	SDOH	64.2%	46.1%
5.1	Percentage of those with poor-to-fair mental health who experienced discrimination and victimization	Stigma and discrim	–	9.1%
5.2	Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community	Stigma and discrim	–	54.4%
5.3	Reported rate of drug-related offences	Stigma and discrim	653	162

Note: Values in the table above that do not have a percentage indicate a rate per 100,000 population

POLICY

Funding

The Northwest Territories government spends less than average on mental health, addictions and substance use (MHASU) health care—approximately only 4% of the overall 2024-2025 healthcare budget will go to mental health, which translates to about $30 million. However, the Northwest Territories is dedicating a higher share of its bilateral health funding to MHASU. The *Working Together Agreement* (2023 Bilateral Health Agreement) and the renewed commitment for the Shared Health Priorities Agreement (2017) represent 38.7% of the total bilateral healthcare funding, approximately $9.5 million, destined to be spent between 2023-2026, which is higher than the Canadian average (31%).[193]

Policy Response to toxic drug supply

The drug toxicity crisis has not impacted the Northwest Territories year over year in the same way as it has other regions in Canada, which may help explain why the territories' opioid harm reduction policy/infrastructure is not as well developed. However, recognizing the significant harms posed by the toxic drug supply, NWT has adopted some harm reduction measures, including the Take Home Naloxone Program (THN) and a drug checking pilot program (fentanyl test strips only).[194] The NWT THN program includes intranasal Narcan, and kits are available at 56 locations across the territory, which is above average distribution relative to the Northwest Territories' low population size and density.

POPULATION MENTAL HEALTH

Although the territories collectively report lower rates of poor-to-fair mental health overall, other indicators suggest that greater harms are experienced in the Northwest Territories due to mental health and substance use. The Northwest Territories has one of the highest rates of hospitalization for self-harm in Canada, 237.2/100,000 (118.6/50,000)[195], and the rate of suicide last year was the highest it has been in 20 years, at 11.5 per 100,000 (5.75 per 50,000), which is also above the national average. Data from the Coroner's Service finds that 18 lives were lost to suicide in 2022, compared to 11 lives lost the previous year. The spike is in part attributed to a higher number of recent deaths by suicide in the Beaufort Delta Region.[196] The suicide rates in NWT's small communities, often remote and isolated, were twice Yellowknife's rate. First Nations communities and youth are disproportionately impacted by suicide in the Northwest Territories.[197] In recent years, there have been critiques that the NWT is not doing enough to prevent suicide and that access to funding for communities is mired in red tape. The 2023-2024 NWT Budget announced $500,000 in annual funding for suicide prevention (up from the previous funding of $250,000 per year), bringing total funding closer to the $1 million that was originally recommended.[198] While NWT does not have a suicide prevention strategy, some regions have developed their own, including the Inuvialuit Regional Corporation.[199]

WORK IN PROGRESS

After recent criticism, NWT funds suicide prevention in response to spike in suicide deaths in remote communities.

Alcohol harms are prevalent in the Northwest Territories. The rates of hospitalization due to alcohol are the highest in the country, at 1,412 hospitalizations per 100,000 (706 per 50,000), compared to the average of 262 per 100,000 in Canada. In response, the NWT government released *An Alcohol Strategy for the Northwest Territories* (2023-2028) which includes a plan for better education, harm reduction, and improved access to addictions treatment services, including culturally appropriate services.[200]

The rate of apparent opioid toxicity deaths reported last year, 7.7 per 50,000, represents seven lives lost. It is the highest reported rate in NWT since 2016 and reflects the higher pandemic-era rates experienced in much of Canada. The apparent opioid toxicity death rates before and after 2022 are lower: in 2021 there were 4 deaths and in 2023 there were 2. When adjusted to the smaller population size, the 2023 rate is 2.2 deaths per 50,000.

NOTEWORTHY

With alcohol-related hospital visits five times higher than average, NWT introduces a new alcohol strategy.

SERVICE ACCESS

The data available for service access in the Northwest Territories, while incomplete, suggest that getting mental health, addictions and substance use (MHASU) supports is difficult. The 30-day hospital readmission rate for MHASU in the Northwest Territories is high at 17.6/100,000, and the data on the MHASU workforce show that there is a lower supply of workers: 1,110.8 per 100,000 (555.4 per 50,000), versus the average in Canada of 1,721.4 per 100,000. The distribution of psychiatrists is particularly low: the rate across all three territories is only 3.2 per 100,000, which translates to 4 psychiatrists in total. The Canadian average, by contrast, is 13.4 psychiatrists/100,000. Residents needing residential treatment must be flown out to facilities in southern Canada, as there is no facility in the Northwest Territories.[201]

FALLING SHORT

Serious shortage of psychiatrists and other mental health, addictions and substance us (MHASU) workers means high hospital readmissions.

MHASU service access in NWT is challenging for several reasons. NWT is one of the most sparsely populated regions in Canada; roughly half of the population lives in Yellowknife and the remaining half is distributed across 33 communities that are only accessible by plane or winter roads.[202] It's a region that experiences extreme environmental conditions, has a limited health services infrastructure and a shortage of mental health providers.[203]

Like in Nunavut, people in Northwest Territories contend with language barriers and a lack of culturally safe and appropriate care, which is significant given that the population is 51% Indigenous and 11 different languages are spoken here.[204] Given the high proportion of First Nations communities, calls have been made for the territorial government to invest more in land- and culture-based mental health services.[vi]

SOCIAL DETERMINANTS OF HEALTH

No data were available across all territories for Indicator *4.1, Core Housing Need for people* reporting poor-to-fair mental health. However, housing need of the general population in the Northwest Territories, at 13.2%, illustrates a critical lack of housing. Housing affordability in the Northwest Territories is particularly a problem for seniors and Indigenous people who are renting. A 2022 report found that 26.6% of Indigenous renters in Yellowknife are unable to afford housing.[205]

STIGMA AND DISCRIMINATION

Data on indicators 5.1 and 5.2 were not available for the Northwest Territories. However, one area of concern is the significantly higher rate of police-reported drug offences in the Northwest Territories, which is about four times the national average at 653 per 100,000 (326.5 per 50,000), compared to the Canadian average of 162 per 100,000.

HIGH ALERT

Police-reported drug offences are about 4 times the national average.

IN FOCUS >

Mental health in NUNAVUT

Population: 44,920

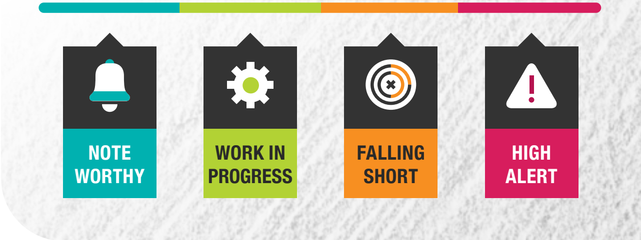
Rural: 54.9%

Highly remote and sparsely populated, Nunavut is home to the largest Inuit communities in the country. Nunavut reports the country's highest rates of suicide and self-harm, and very high rates of hospitalizations due to alcohol. These harms are linked to the social and health inequalities experienced by the population due to colonialism. Child poverty is alarmingly high, food security is a serious concern and the general population's housing need is triple the national rate. The data on service access are scarce, but we know that Nunavut has about one third the mental health, addictions and substance use (MHASU) health care providers compared to the national average. This much smaller workforce tends to be transient and primarily non-Indigenous, which negatively impacts trust, continuity of care and compromises access to culturally and language-appropriate services. Change is coming, however, with innovations like training Inuit paraprofessionals to provide mental health supports; the testing of a land-based mobile addiction treatment program; and a new Inuit-designed addictions and trauma treatment centre in Iqaluit. Nunavut modernized its *Mental Health Act* in 2021 and it now better reflects Nunavummiut cultural values, including allowing for greater family involvement when someone is ill.

IN FOCUS: NUNAVUT

Indicator		Indicator Category	NU	CAN
1.1a	Mental health, addictions, and substance use (MHASU) Healthcare Investments	Policy	10%	6.3%
1.1b	Bilateral Health Spending for MHASU	Policy	17.8%	31%
1.2	MHASU Strategy	Policy	Out of date	Out of date
1.3	Decriminalization policy	Policy	–	Low support
1.4	Harm reduction policy	Policy	Ins.	High support
1.5	Mental Health Acts	Policy	No/low concern	–
2.1	Perceived mental health – poor/fair	Population Mental Health (MH)	23.3%	26.1%
2.2a	Prevalence of mood/anxiety disorders (12-month)	Population MH	–	10.6%
2.2b	Prevalence of substance use disorders (lifetime)	Population MH	–	20.7%
2.3	Rate of death by suicide	Population MH	72.2	10.9
2.4	Rate of hospitalization for self-harm	Population MH	360.3	64.9
2.5	Rate of apparent opioid toxicity deaths	Population MH	–	20.8
2.6	Rate of hospitalizations caused entirely by alcohol	Population MH	757	262
3.1	Percentage of population needing mental health care but needs are unmet or partially met	Service access	–	7.8%
3.2	Percentage of youth with early MHASU service needs who accessed Community Mental Health services	Service access	–	61%
3.3	Number of psychiatrists per 100,000 population	Service access	3.2	13.1
3.4	Supply of MHASU healthcare providers	Service access	676.8	1,721.4
3.5	30-day hospital readmission rates for MHASU concerns	Service access	12.3%	13.4%
4.1	Percentage of population reporting poor-to-fair mental health in core housing need	Social Determinants of Health (SDOH)	–	15.8%
4.2	Poverty rate	SDOH	–	8.1%
4.3	Employment rate for individuals with mental health disabilities (ages 25-64)	SDOH	43.1%	46.1%
5.1	Percentage of those with poor-to-fair mental health who experienced discrimination and victimization	Stigma and discrim	–	9.1%
5.2	Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community	Stigma and discrim	–	54.4%
5.3	Reported rate of drug-related offences	Stigma and discrim	155	162

Note: Values in the table above that do not have a percentage indicate a rate per 100,000 population



IN FOCUS: NUNAVUT

POLICY

Funding

For 2024-2025, the Nunavut government announced it would be spending approximately $54 million on mental health, addictions and substance use (MHASU) health care, which is 10% of the overall health spending. It should be noted that, while this is a higher percentage than average, Nunavut dedicates a smaller share of its budget to health care: only about 25% of its budget, as compared to other Canadian provinces that direct between 30-44% of spending to health care. The new *Working Together Agreement* (2023 Bilateral agreement) struck between Nunavut and the Government of Canada includes $4.3 million for MHASU over the period of 2023-2026, or 17.8% of the funding, which is lower than the national average (31%). This funding will go to training, capital costs for mental health programming, integrated mental health (MH) teams and virtual MH services[206] and the remaining 2017 funding of $781,150 will be dedicated to training (culturally appropriate MH services), trauma symposia and an integrated youth services space.

Strategy

Nunavut's two mental health strategies, the *INUUSIVUT ANNINAQTUQ Action Plan 2017-2022* and the Nunavut Suicide Prevention Strategy (2017-2022) have ended,[207] so beyond what was outlined in the new *Working Together Agreement*, the territory's long-term plans for enhancing health and wellness are not known.

FALLING SHORT

Nunavut's mental health strategies are stale-dated making its long-term plans unclear.

Mental Health Act

One of the recommendations of Nunavut's suicide prevention strategy was to revise the territory's *Mental Health Act* to address its high rates of suicide and to modernize the legislation so that it is more reflective of the cultural values of Nunavummiut. The Act was subsequently updated in 2021 and includes new rules about language rights, the creation of an independent Mental Health Review Board and provisions for greater family involvement when someone is ill, for instance to allow the appointment of a tikkuaqtaujug (selected representative) to make decisions about care. It also includes provisions for community treatment orders.[208]

NOTEWORTHY

The Mental Health Act now better reflects Nunavummiut cultural values, allowing for more family involvement when someone is ill.

POPULATION MENTAL HEALTH

Distressingly, Nunavut reports the highest rates of suicide and self-harm in all of Canada: in 2022, the rates were 72/100,000 (36/50,000)[209] for suicide and 360.3/100,000 (180/50,000) for self-harm. The suicide rates in Inuit Nunangat are estimated to be five to 25 times higher than in the rest of Canada, and youth are disproportionately impacted. Advocates have been urging the declaration of suicide as a public health emergency to ensure the allocation of more resources for suicide prevention in the territory.[210] Historical data show that suicides in Nunavut were rare before the 1970s and rose sharply when communities were forced by the federal government into housing settlements that were often inadequate and lacked proper sanitation and clean water. The Inuit National Suicide Prevention Strategy identifies the social determinants of health as priority areas for action to prevent suicide in Nunavut: addressing housing, income, food security, education and early childhood development, culture and language and access to health services, including mental health services, all of which are critically important for reducing the risk factors for suicide.[211]

HIGH ALERT

Nunavut's suicide and self-harm rates are the highest in the country, with youth hit hardest.

Nunavut also experiences significantly higher harms due to alcohol. The rate of hospitalizations entirely due to alcohol sits at 757 per 100,000 population (378.5 per 50,000), far above the average in Canada of 262 per 100,000.

SERVICE ACCESS

Unfortunately, there are limited data for Nunavut when it comes to the service access indicators. However, the two indicators for which there are data suggest significant barriers to services. Nunavut has a very low number of mental health, addictions and substance use (MHASU) health care providers: 676.8 per 100,000 (338.4 per 50,000) compared to the national average of 1,721.4/100,000. As many communities in Nunavut are highly remote—either fly-in or with limited road access—maintaining and retaining a MHASU workforce is difficult. The specialized MHASU workforce tends to be transient: practitioners may only stay for short periods or are flown in for scheduled visits from southern urban centres. This instability can create problems in establishing trust relationships and ensuring continuity of care. Given the inadequate numbers of practitioners and services, many Inuit are flown to southern communities for treatment.[212]

WORK IN PROGRESS

The small mental health, addictions and substance use (MHASU) health workforce is transient and primarily non-Indigenous but innovations like Inuit paraprofessionals are promising.

Additionally, services are not necessarily culturally or language appropriate and accessible, as many of the providers are non-Indigenous and/or may be outsiders to the communities they are serving. These barriers are commonly cited as challenges to accessing service, including the short supply of Inuktitut and French language services in Nunavut.[213]

Although the workforce shortage and the scarcity of culturally appropriate care present significant barriers to services, a promising new practice trains paraprofessionals who are Inuit to provide mental health supports that are culturally appropriate and trauma-informed within communities, and prevents the need for travel.[214] Other innovative solutions like the land-based mobile addiction treatment program near Cambridge Bay are also being tested. In addition, last year, Nunavut announced a historic investment of $83.7 million to build Aqqusariaq, an Inuit-designed addictions and trauma treatment centre in Iqaluit, which will fill an important need for local substance use treatment services.[215]

SOCIAL DETERMINANTS OF HEALTH

Problematically, important data on the social determinants of health for Nunavut are missing even though the social inequities experienced by Inuit communities in Nunavut are substantial. The Market Basket Measure (MBM) currently does not exist for Nunavut,[216] but data on child poverty for the territory from 2021 indicates that 35.8% of children under 18 years lived in poverty and that percentage increases to 43.2% for children under six.[217] Data for Indicator 4.1, *Core Housing Need* for those rating their mental health as poor-to-fair was also not available for Nunavut, but the data for the general population were available and indicate that the need in Nunavut is triple Canada's rate, at 32.9%.[218] In addition, Nunavut reports that 35% of dwellings in the territory are considered overcrowded.[219]

Food security is also a major problem in the circumpolar north. In Nunavut, the rate of moderate-to-severe food insecurity is reported to be 49.4%, compared to 8.8% for all of Canada.[220]

STIGMA AND DISCRIMINATION

Data on stigma and discrimination indicators 5.1 and 5.2 were not available for Nunavut. Unlike the other territories, Nunavut's rate of drug-related offenses is slightly below the national average, at 155 compared to 162 per 100,000.

RECOMMENDATIONS AND CONCLUSION

The national mental health and substance use health data in this report sound the alarm that Canada must improve the mental health of its people and enhance access to mental health, addictions and substance use (MHASU) care and social supports. While COVID-19 brought a heightened awareness of mental health and its importance, the evidence here demonstrates that this awareness has not adequately translated into the policies needed for systemic change. Since the pandemic, people in Canada have experienced an increase in poor mental health, a rise in deaths due to the toxic drug supply and increased hospitalizations due to alcohol. Further, very high rates of suicide among Canada's northern First Nations and Inuit peoples are a devastating sign that Canada is failing to meet its obligations and commitments to Indigenous Peoples. Our MHASU care systems are piecemeal, and crudely stitched together such that each province and territory provides an inconsistent assortment of services. One's experience of MHASU care depends dramatically on where one lives: in which province or territory; and whether in a rural, northern or urban location. Canada requires a coherent and comprehensive MHASU system that serves the population equally across the provinces and territories.

The evidence also suggests that people living with mental health-related disabilities need better income supports, employment opportunities, and safe and secure housing and that social inequities that lead to poor mental health, like poverty, must be remedied.

Only strong federal leadership can alter the course Canada is on. Only the federal government can bring all mental health, addictions and substance use (MHASU) care into the publicly funded healthcare system and finance it adequately, while collaborating with provinces and territories to make MHASU health a priority.

Finally, the national data on which this report is based are themselves piecemeal, inconsistent and, at times, of poor quality. If we are to foster mental well-being for people in Canada, we need to collect more and better data that show what we're doing well, and where we can do better. We must also address the inequities in data coverage and quality across provinces and territories, and support northern performance measurement initiatives, in partnership with Indigenous communities, so that we are tracking population health needs and service access in ways that reflect the cultures and values of Indigenous communities. Based on the evidence and findings in this report, we make the following recommendations.

RECOMMENDATIONS

GOVERNANCE AND INVESTMENT

The Government of Canada must invest 12% of health spending in mental health, addictions and substance use (MHASU) health care and create a stronger legislative framework to govern spending. This means:

- Increasing funding for MHASU to $6.25 billion annually so that spending is in line with peer countries, at no less than 12% of the overall healthcare budget.
- Establishing a predictable funding stream and legislative accountability mechanism that guarantees coverage for MHASU services beyond those delivered by physicians or in hospitals, in one of two ways. The first way is to amend the *Canada Health Act* to explicitly include mental health and substance use healthcare services delivered in community settings. The other way is to create parallel legislation for mental health and substance use health care and accompanied by a funding transfer that includes robust accountability measures for provinces and territories, and, at minimum, adheres to the principles of public administration, comprehensiveness, universality, portability, and accessibility.

EQUITY

The Government of Canada must increase social spending and enhance social supports so that people with mental health-related disabilities and those experiencing other forms of systemic discrimination have the livable incomes and adequate housing they need to be well. This means:

- Introducing a Universal Basic Income (UBI) program to address poverty. The Government of Canada should consider beginning with three basic income pilot projects, designed to study how a federal-wide program could be administered.
- Reorienting the Canada Disability Benefit (CDB) to serve as a poverty reduction measure, indexing the benefit to inflation—similar to other federal income support programs like the Guaranteed Income Supplement for seniors—and ensuring that people with mental health disabilities can qualify.
- Earmarking federal housing dollars for operating costs associated with supportive and transitional housing and ensuring collaboration with the provinces and territories to build and sustain affordable non-market-based housing units.
- Addressing the social inequities experienced by racialized and Indigenous peoples in consultation with those communities and people with lived experience of mental illnesses, addictions and substance use problems to ensure supports are culturally appropriate and respond to people's needs.

DATA

The Government of Canada needs to collect more and better data to track and improve our mental healthcare system. This means:

- Consulting with people with lived experience of mental illnesses, addictions and substance use disorders, Indigenous Peoples, youth, Black and racialized peoples, and 2SLGBTQ+ and other experts to establish a more comprehensive set of indicators for mental health, addictions and substance use (MHASU).
- Working with the provinces and territories to strengthen consistent data collection across a comprehensive set of performance indicators.
- Increasing funding to community-based mental health organizations to improve efforts to collect, track, and publicly report on mental health, addiction, and substance use healthcare metrics and ensure that health outcomes from community service delivery are integrated with data collection in the acute and primary health sectors.
- Better supporting northern regions to collect and report data.

Canada has signed international declarations affirming that all people in Canada have the right to the highest attainable standard of health and to non-discrimination on the basis of disability. Honouring those commitments will take significantly stronger federal funding and policy in mental health, addictions and substance use health care and investments in the social supports that keep people well.

APPENDIX A:
DATA TABLES

Table 1.0 – Policy

Indicator	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL	YT	NT	NU	CANADA
1.1a Mental health, addictions and substance use (MHASU) Healthcare Investments (2024-2025)	Ins.	5.5% ($1.55 B)	7.5% ($574 M)	5.6%* ($439 M)	5.9% ($2 B)	Ins.	6% ($229 M)	4.9% ($359 M)	6.9% ($77.5 M)	Ins.	6.4% ($43 M)	4% ($30 M)	10% ($54 M)	6.3% (National average
1.1b MHASU Healthcare Investments: Bilateral Health Spending for MHASU (2023)	20.1% ($246 M)	40% ($426 M)	35% ($81.6 M)	15% ($65.1 M)	40.5% ($431.2 M)	Ins.	14.8% ($46.2 M)	16.3% ($58 M)	8.3% ($7.8 M)	19.1% ($48.95 M)	77% ($18.38 M)	38.7% ($9.45 M)	17.8% ($4.26 M)	31% ($903 M) (National average)
1.2 MHASU Strategy	Highly comprehensive Active strategy; details on targets and progress found in ancillary progress report published in 2023. Funding in provincial budget estimates.	Out of date	Moderately comprehensive Active strategy; priorities identified but light on accountability and funding details. By year 5, plan to spend $49.4M on the action items in the report	Somewhat comprehensive Active strategy; but it is vague. $17.1M funding for year 1 and $23.7million to support ongoing initiatives aligning with plan priorities	Moderately comprehensive Active strategy, incl. $3.8B action plan over 10 years. Specific areas of investment and accountability not clearly mapped out.	Highly comprehensive Active strategy, incl. Indicators with expected outcomes. Noted elsewhere that there is $1.2B action plan attached	Moderately comprehensive Active strategy; incl. accountability framework but unclear how progress monitored; no funding attached. Progress may be reported in the Provincial Health Plan.	Out of date	Somewhat comprehensive Active strategy; no specific programs identified or funding attached. No info on plans to measure progress	Out of date	Moderately comprehensive Active strategy; Includes strategic priorities and commitment to quarterly progress reports, but no or limited info on investment.	Out of date	Out of date	Out of date (2012) (Federal Policy)

Indicator	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL	YT	NT	NU	CANADA
1.3 Decriminalization policy (federal only) (2024)	–	–	–	–	–	–	–	–	–	–	–		–	Low support: No *de jure* legislation; but enacted *de facto* guidance. Considers PT exemptions to CDSA for personal possession
1.4 Harm reduction policy (2024)	High support: Naloxone OPS/SCS/CTS Drug checking safer supply	Moderate Support: Naloxone OPS/SCS/CTS	Moderate Support: Naloxone Drug checking	Moderate Support: Naloxone OPS/SCS/CTS	Moderate Support: Naloxone OPS/SCS/CTS	Moderate-to-high support: Naloxone OPS/SCS/CTS Drug checking	Moderate Support: Naloxone OPS/SCS/CTS	Moderate Support: Naloxone OPS/SCS/CTS	Moderate Support: Naloxone Drug checking	Moderate Support: Naloxone Drug checking	High support: Naloxone OPS/SCS/CTS Drug checking safer supply	Moderate Support: Naloxone Drug checking	Ins.	High support: Naloxone OPS/SCS/CTS Drug checking safer supply (Federal Policy)
1.5 Mental Health Acts (2024)	High concern: Reviewed 2022; independent rights advice service now established, "deemed consent" remains ongoing concern	High concern: Reviewed 2022; No Mental Health Advocate in the province and proposed Compassionate Intervention legislation	Ins.	Low concern	Moderate concern; last amended in 2015; growing use of CTOs and substitute decision makers flagged as a possible problem	Moderate concern: Not reviewed since 2002; based on civil code rather than common law; strongly rights based. Courts can require involuntary admission/ treatment	High concern; Reviewed 2024; but no Mental Health Advocate and concern re: proposed Compassionate Intervention legislation. Concerns about patient rights and oversight raised with lawsuit and settlement in 2019 following complaints of physical and sexual abuse from psychiatric patients detained at RHC hospital.	Ins.	Low concern; reviewed in 2023; CTOs added	Low concern	Ins.	Ins.	Low concern; reviewed 2021; rooted in commitment to culturally safe practices, care in the community and encourages the use of voluntary services; Act recognizes the role of tikkuaqtaujuit and req. Inuit cultural advisors on the Mental Health Review Board	-

*Manitoba estimates are based on 2023-2024 expenditures, as 2024-2025 breakdown for MHASU was not available

Table 2.0 – Population Mental Health

Indicator	Measure	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL	YT	NT	NU	CANADA
2.1 Perceived mental health – poor-to-fair (2021)	% of those surveyed, (N)	28.1% (1,865)	29.3% (1,141)	25.3% (296)	27.3% (369)	26.4% (5,848)	18.4% (1,030)	27.9% (268)	28.8% (904)	18.3% (38)	30% (165)	23.3% (80)			26.1% (12,004)
2.2a Prevalence of mood and anxiety disorders in Canada: Combined Average[i] (2022)	%	9.9	11.9	15.5	10.5	10.9	8.6	14.5	13.9	–	8.7	–	–	–	10.6
2.2b Prevalence of substance use disorders in Canada: SUDs (2022)	%	25.2	24.4	27.5	24.5	18.9	17.1	27.9	23.8	–	14.9	–	–	–	20.7
2.3 Rate of death by suicide (2020)	Age-standardized rates per 100,000	6.9	14.3	17.6	13.9	9.6	12.2	11.8	11.0	4.1	10.9	–	11.5	72.2	10.9
2.4 Rate of hospitalization for self-harm (2020)	Age-standardized rates per 100,000 (ages 10+)	75.0	52.2	87.7	38.7	63.0	68.9	59.3	43.2	78.6	94.2	204.8	237.2	360.3	64.9
2.5 Rate of apparent opioid toxicity deaths (2023)	Crude rates per 100,000 population (N)	46.6 (2,574)	39.4 (1,848)	24 (290)	3.7* (52)	16.6 (2,593)	6.0 (536)	8.6 (72)	7 (74)	4 (7)	6.7 (36)	37.8 (17)	4.4 (2)	–	20.8 (8,049)
2.6 Rate of hospitalization entirely caused by alcohol (2022-2023)	Rate per 100,000	385	333	375	259	214	210*	142	280	248	187	948	1412	757	262

[i] Includes: mood disorder, depression, bipolar disorder, mania, or dysthymia, anxiety disorder, phobia, OCD, panic disorder

* In 2023, the crude rate and number of apparent opioid toxicity deaths are missing for Manitoba. The 2022 numbers are reported here.

Table 2.1 - Indicator 2.2 Prevalence of disorders in Canada

Indicator 2.2 Prevalence of mood or anxiety disorders in Canada	**Mood Disorder*** (i.e., mood disorder, depression, bipolar disorder, mania, or dysthymia)		(i.e., any other mood disorder)		(i.e., anxiety disorder, phobia, OCD, panic disorder)	
Measure	% with mood disorder	Rate per 100,000	% with mood disorder	Rate per 100,000	% with anxiety disorder	Rate per 100,000
PROVINCE						
Newfoundland and Labrador	8.3	–	–	–	9.0	–
Prince Edward Island	–	–	–	–	–	–
Nova Scotia	15.0	15,017	0.7	–	12.7	12,743
New Brunswick	14.7	14,660	1.3	–	14.2	14,253
Québec	8.3	8,342	1.1	1,093	8.9	8,927
Ontario	11.3	11,266	1.5	1,542	10.4	10,389
Manitoba	12.1	12,132	0.4	–	8.8	8,819
Saskatchewan	15.6	15,585	2.8	–	15.4	15,448
Alberta	13.0	12,993	0.8	–	10.7	10,707
British Columbia	11.2	11,246	0.5	–	8.5	8,514
Northwest Territories	–	–	–	–	–	–
Yukon	–	–	–	–	–	–
Nunavut	–	–	–	–	–	–
Canada	11.1	11,066	1.2	1,161	10.0	10,050

Indicator:	Anxiety Disorder (other)* (i.e., any other anxiety disorder)				Substance use disorder (lifetime) (i.e., includes alcohol or drug, over life)	
Measure	% with anxiety disorder	Rate per 100,000	% with alcohol dependence	Rate per 100,000	% with any SUD	Rate per 100,000
PROVINCE						
Newfoundland and Labrador	2.3	–	–	–	14.9	14,888
Prince Edward Island	–	–	–	–	–	–
Nova Scotia	3.7	–	–	–	23.8	23,822
New Brunswick	6.4	–	–	–	27.9	27,943
Québec	4.2	4,163	0.6	574	17.1	17,130
Ontario	4.7	4,731	1.1	1,069	18.9	18,865
Manitoba	3.3	–	0.1	–	24.5	24,474
Saskatchewan	3.2	–	0.4	–	27.5	27,493
Alberta	4.1	4,117	0.8	–	24.4	24,401
British Columbia	3.4	3,407	1.4	1,360	25.2	25,250
Northwest Territories	–	–	–	–	–	–
Yukon	–	–	–	–	–	–
Nunavut	–	–	–	–	–	–
Canada	4.2	4,232	0.8	842	20.7	20,656

Indicator:	Substance use disorder(SUD) (in the last 12 months) (i.e., includes alcohol or drug, in the last 12 months)	
Measure	% with any SUD in the last 12 months	Rate per 100,000
PROVINCE		
Newfoundland and Labrador	–	–
Prince Edward Island	–	–
Nova Scotia	2.4	–
New Brunswick	2.0	–
Québec	3.8	3,843
Ontario	3.9	3,944
Manitoba	3.8	3,797
Saskatchewan	3.2	–
Alberta	3.8	3,785
British Columbia	4.5	4,462
Northwest Territories	–	–
Yukon	–	–
Nunavut	–	–
Canada	3.8	3,808

*Prevalence notes:

- **Mood disorders include** responses of “yes” to: “has a mood disorder, depression, bipolar disorder, mania, or dysthymia”
- Mood disorders (other) includes any other mood disorder
- **Anxiety disorders include** responses of “yes” to: “has an anxiety disorder, phobia, OCD, panic disorder”
- Anxiety disorders (other) includes any other anxiety disorder

Table 3.0 – Access to Mental Health and Substance Use Treatment

Indicator	Measure	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL	YT	NT	NU	CANADA
3.1 Percentage who needed mental health care but their needs were either unmet or partially met (2023)	% (N of people with unmet care needs)	9.4% (369,000)	9.0% (316,000)	6.6% (58,700)	8.4% (85,900)	7.8% (915,100)	6.6% (462,500)	6.3% (38,700)	7.8% (61,100)	6.7% (8,400)	6.0% (26,000)	–	–	–	7.8% (2,341,200)
3.2 Percentage of youth aged 12-24 with early MHASU service needs who accessed community-based mental health and substance use services in the last 6 months (2022)	% (N)	68% (205)	62% (197)	48% (30)	52% (43)	61% (406)	–	45% (24)	72% (38)	–	–	–	–	–	61% (1,274)
3.3 Number of psychiatrists in Canada per 100,000 population (2019)	Number of psychiatrists per 100,000 (Total N in Province)	14.8 (747)	10.6 (461)	7.4 (87)	13.3 (181)	13.4 (1,938)	14.4 (1,215)	6.6 (51)	14.5 (140)	5.2 (8)	11.6 (61)	3.2 (4)			13.1 (4,893)
3.4 Supply of MHASU healthcare providers in Canada (2021)	Number per 100,000 population (Total N in province)	1,446.8 (74,635)	1,907.2 (84,299)	1,907.5 (22,495)	1,862.2 (25,710)	1,609.9 (237,392)	1,817.0 (155,864)	2,067.5 (16,193)	2,224.9 (21,846)	1,957.5	2,203.6	2,205.2 (930)	1,110.8 (504)	676.8 (265)	1,721.4 (654,780)
3.5 30-day hospital readmission rates for MHASU concerns (2022-2023)	% (Total number of readmissions)	15.3 (4,600)	11.3 (2,351)	11.5 (771)	10.7 (600)	13.7 (8,652)	13.0 (5,070)	12.2 (447)	10.3 (381)	12.1 (114)	12.6 (284)	15.1 (52)	17.6 (91)	12.3 (51)	3.4 (24,252)

Reporting Notes:
*denotes missing
**denotes sample size too small to determine representative %
Risk Adjusted Rate = Total number of individuals with the given indicator/Proportional denominator of individuals in the population

Table 4.0 – The Social Determinants of Health/Access to the prerequisites of mental health

Indicator	Measure	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL	YT	NT	NU	CANADA
4.1 Percentage of Canadians reporting poor-to-fair mental health in core housing need (2021)	% (N)	19.1% (172)	17.4% (177)	16.3% (112)	14.7% (84)	18.1% (291)	9.9% (69)	13.4% (104)	16.9% (109)	9.7% (30)	16.8% (75)	–	–	–	15.8% (1,233)
4.2 Poverty rate (Market Basket Measure) (2020)	%	9.8%	8.1%	8.4%	8.6%	8.3%	6.4%	8.1%	9.8%	8.7%	8.2%	8.8%	10.2%	–	8.1%
4.3 Employment rate for individuals with mental health disabilities (ages 25-64) (2017)	%	50.3%	53.9%	58.8%	51.6%	43.0%	41.6%	44.0%	44.0%	49.9%	40.9%	64.9%	64.2%	43.1%	46.1%

Table 5.0 – Stigma, discrimination and mistreatment

Indicator	Measure	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NL	YT	NT	NU	CANADA
5.1 Percentage of Canadians with poor-to-fair mental health who experienced discrimination and victimization (2019)	% (N)	10.9% (29)	Prairie region: 9.9% (67)			10.3% (51)	5.6% (9)	Atlantic Region: 7.1% (35)				–	–	–	9.1% (191)
5.2 Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community (2020)	% (N)	56.8% (249)	49.7% (190)	51.8% (85)	54.5% (116)	55.4 % (755)	53.7% (249)	55.9% (81)	55.9% (114)	54.4% (74)	54.6% (71)	–	–	–	54.4% (1,984)
5.3 Rate of police-reported drug offences (2021)	Rate per 100,000 population (N)	343 (17,880)	146 (6,506)	206 (2,434)	158 (2,182)	98 (14,502)	167 (14,409)	158 (1,246)	96 (955)	76 (125)	171 (892)	633 (297)	653 (272)	155 (61)	162 (61,798)

- denotes missing
** denotes sample size too small to determine representative %
Risk Adjusted Rate = Total number of individuals with the given indicator/Proportional denominator of individuals in the population

APPENDIX B:

SOURCES AND CONTEXTUAL NOTES FOR DATA COLLECTION

Indicator	Indicator Category
1.1a Mental health, addictions and substance use (MHASU) Healthcare Investments	**Data Source:** BC: https://www.bcbudget.gov.bc.ca/2024/pdf/2024_Budget_and_Fiscal_Plan.pdf AB: https://open.alberta.ca/dataset/23c82502-fd11-45c6-861f-99381fffc748/resource/3782cc8f-fdc4-4704-9c50-07fc36e05722/download/budget-2024-fiscal-plan-2024-27.pdf SK: https://budget.saskatchewan.ca/pub/docs/budget-docs/22948-2024-25-budget-document-web.pdf MB: https://www.gov.mb.ca/asset_library/en/budget2024/budget2024.pdf ON: https://budget.ontario.ca/2024/pdf/2024-ontario-budget-en.pdf QC: https://www.finances.gouv.qc.ca/Budget_et_mise_a_jour/budget/documents/Budget2425_PlanBudgetaire.pdf NB: https://legnb.ca/content/house_business/60/3/tabled_documents/2024-2025%20Main%20Estimates%20BIL.pdf NS: https://beta.novascotia.ca/sites/default/files/documents/6-460/ftb-bfi-020-en-budget-2024-2025.pdf PEI: https://docs.assembly.pe.ca/download/dms?objectId=9abfe316-e0fe-4f13-8cbc-bd4481e6c501&fileName=Premier.King.02292024.2024-25%20Estimates%20of%20Revenue%20and%20Expenditure.pdf NL: https://www.gov.nl.ca/budget/2024/wp-content/uploads/sites/8/2024/03/The-Economy-2024.pdf YT: https://yukon.ca/sites/yukon.ca/files/fin/fin-2024-25-budget-main-estimates.pdf NT: https://www.fin.gov.nt.ca/sites/fin/files/2024-25_main_estimates.pdf NU: https://www.gov.nu.ca/sites/default/files/documents/2024-02/Main%20Estimates%202024-25%20%28EN%29.pdf **Analytic Notes:** • MHASU spending for the provinces and territories were extracted from the Budget Estimates 2024-2025 for each province and territory, if they were available, and formatted in Excel. Percentages were calculated by dividing the total dollar amount for MHASU by the total dollar amount for health care for each province and territory. **Other notes:** • Data were unavailable for British Columbia, Québec and Newfoundland and Labrador. Data for 2024-2025 were also unavailable for Manitoba, but they were available for 2023-2024.

Indicator	Indicator Category
1.1b Bilateral Health Spending for MHASU	**Data Source:** BC: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements/british-columbia-improve-care.html AB: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements/alberta-improve-care.html SK: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements/saskatchewan-improve-care.html MB: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements/manitoba-improve-care.html ON: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements/ontario-improve-care.html QC: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements/quebec-improve-care.html NB: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements/new-brunswick-improve-care.html NS: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements/nova-scotia-improve-care.html PEI: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements/prince-edward-island-improve-care.html NL: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements/newfoundland-labrador-improve-care.html YT: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements/yukon-improve-care.html NT: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements/northwest-territories-improve-care.html NU: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements/nunavut-improve-care.html **Analytic Notes:** • MHASU spending for the 2023 Bilateral funding (which includes remaining 2017 Bilateral funding) destined to be spent from 2023-2026 were extracted from the data tables from each *Agreement* and formatted in Excel. Percentages were calculated by dividing the dollar amount for MHASU by the total dollar amount for the Bilateral agreements for each province and territory.

Indicator		Indicator Category
1.2	MHASU Strategy	**Data Source:** BC: https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/initiatives-plans-strategies/mental-health-and-addictions-strategy/bcmentalhealthroadmap_2019web-5.pdf SK: https://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/saskatchewan-health-initiatives/mental-health-and-addictions-action-plan MB: https://www.gov.mb.ca/asset_library/en/mhcw/docs/roadmap.pdf ON: https://www.ontario.ca/page/roadmap-wellness-plan-build-ontarios-mental-health-and-addictions-system https://www.ontario.ca/page/published-plans-and-annual-reports-2023-2024-ministry-health QC: https://publications.msss.gouv.qc.ca/msss/fichiers/2021/21-914-14W.pdf; Un investissement de plus de 1 milliard $ en santé mentale - La Relève (lareleve.qc.ca) NB: https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/MentalHealthandAddictions/inter-departmental_addiction_and_mental_health_action_plan.pdf PEI: https://www.princeedwardisland.ca/en/publication/mental-health-and-addiction-strategy-2016-2026 YT : https://yukon.ca/sites/yukon.ca/files/hss/hss-imgs/hss-mentalwellnessstrategy.pdf **Other notes:** • Strategies for Alberta, Newfoundland and Labrador, Nova Scotia, Northwest Territories and Nunavut are not available as they are out-of-date.
1.3	Decriminalization policy (federal only)	**Data Source:** • https://www.ppsc-sppc.gc.ca/eng/pub/fpsd-sfpg/fps-sfp/tpd/p5/ch13.html

Indicator		Indicator Category
1.5	Mental Health Acts	**Data Source:** BC: https://www.healthjustice.ca/fast-facts-mha; https://bcombudsperson.ca/assets/media/Committed-to-Change_Report-Update_July21-2022.pdf AB: open.alberta.ca/dataset/0c69e9e5-5e1f-43d3-aca0-3464a147fb19/resource/404a31eb-242b-4bfe-933d-73af6b4e4828/download/health-mhrp-response-treating-people-with-mental-illness-fairly-progress-report-2020-2021.pdf MB: https://www.ombudsman.mb.ca/uploads/document/files/2022-23-annual-report-web-en.pdf ON: https://files.ontario.ca/moh-third-review-community-treatment-orders-dec-2019-en-2023-03-09.pdf https://www.ontario.ca/laws/statute/90m07 QC: https://www.legisquebec.gouv.qc.ca/en/document/cs/p-41;%20Bernheim%20report NB : https://www.canlii.org/en/nb/laws/stat/rsnb-1973-c-m-10/latest https://www.cbc.ca/news/canada/new-brunswick/class-action-settlement-restigouche-hospital-psychiatric-patients-judge-approved-campbellton-1.7008749 NS : https://novascotia.ca/dhw/mental-health/documents/ipta/IPTA_Facts_for_Law_Enforcement.pdf https://nslegislature.ca/legc/bills/59th_1st/1st_read/b109.htm PEI: https://www.princeedwardisland.ca/en/legislation/mental-health-act https://www.cbc.ca/news/canada/prince-edward-island/pei-mental-health-legislature-act-1.7027073#:~:text=P.E.I.%27s%20new%20Mental%20Health%20Act%20passed%20second%20reading,mental%20health%20team%20outside%20of%20a%20hospital%20setting. NL: www.lghealth.ca/wp-content/uploads/2018/04/MHCTA-PPT.compressed.pdf NT: https://www.canlii.org/en/nu/laws/stat/rsnwt-nu-1988-c-m-10/105026/rsnwt-nu-1988-c-m-10.html#document **Other notes:** • Insufficient information for: Saskatchewan, Nova Scotia, Yukon and Northwest Territories.

Indicator	Indicator Category
2.1 Perceived Mental health – poor-to-fair	**Data Source:** • Statistics Canada. (2021). Canadians' Mental Health Public Use Microdata File (2020) available via: https://www150.statcan.gc.ca/n1/pub/13-25-0002/132500022020001-eng.htm https://www150.statcan.gc.ca/n1/en/catalogue/13250002 **Analytic Notes:** • Variables from .CSV file were uploaded to SAS 9.4, formatted, and transposed for cross tabulation of mental health status across provinces/territories. • Cross tabulation analysis of mental health status by province and territory. **Other Notes:** • Data include the COVID period which may over/underestimate ratings of mental health.
2.2a Prevalence of mood and anxiety disorders in Canada: Mood/ anxiety disorders (Combined average, 12-month prevalence) **2.2b** Prevalence of substance use disorders (lifetime prevalence)	**Data Source:** • Statistics Canada. (2022). Mental Health and Access to Care Survey, 2022. Reproduced and distributed on an "as is" basis with the permission of Statistics Canada. Data dictionary, and questionnaire are available via: https://www.statcan.gc.ca/en/statistical-programs/instrument/5015_Q2_V1 **Analytic Notes:** • Variables from .CSV file were uploaded and formatted. The total population estimates were based on estimates of "yes" or "no" for each disorder. Percentages were determined by using the reported % or using the % of individuals without a given disorder to calculate those with a given disorder. When available, the total number of individuals with each disorder was divided by the total population estimates and multiplied by 100,000 to determine rates per 100,000.
2.3 Rate of death by suicide	**Data Source:** • Government of Canada. (2023). Suicide, self-harm, and suicide-related behaviours in Canada (2020): Suicide mortality, available via: https://health-infobase.canada.ca/mental-health/suicide-self-harm/suicide-mortality.html **Analytic Notes:** • The age-standardized suicide mortality rate per 100,000 people based on ICD codes (X60-X84 and Y87) were reported.

Indicator	Indicator Category
2.4 Rate of hospitalization for self-harm	**Data Source:** • Government of Canada. (2023). Suicide, self-harm, and suicide-related behaviours in Canada: Self-harm, available via: https://health-infobase.canada.ca/mental-health/suicide-self-harm/self-harm.html **Analytic Notes:** • The age-standardized self-harm hospitalization rate per 100,000 people based on ICD codes (X60-X84) were reported.
2.5 Rate of apparent opioid toxicity deaths	**Data Source:** • Government of Canada. (2024). Opioid- and Stimulant-related Harms in Canada (2023), available via: https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/maps.html **Analytic Notes:** • Crude rate per 100,000 population, and N reported for number of apparent deaths due to opioid toxicity.
2.6 Rate of hospitalization entirely caused by alcohol	**Data Source:** • Canadian Institute for Health Information. (2024), available via: https://yourhealthsystem.cihi.ca/hsp/inbrief#!/indicators/061/hospitalizations-entirely-caused-by-alcohol/;mapC1;mapLevel2;trend();/ **Analytic Notes:** • Reported rates per 100,000 across Canada • Missing data for Québec from 2022-2023. The rate of hospitalizations caused entirely by alcohol for Québec was reported for 2021-2022.

Indicator		Indicator Category
3.1	Percentage of population needing mental health care but their needs were either unmet or partially met (2023)	**Data Source:** • Statistics Canada. (2023). Canadian Community Health Survey – Annual Component; Mental health characteristics: Perceived need for mental health care, available via: https://www150.statcan.gc.ca/t1/tbl1/en/cv.action?pid=1310061901 • Uploaded "All_Canada.csv", and imported datafile into SAS. Individuals who reported that they perceived a need for mental health care were determined. Percentages (i.e., percent of persons with a need) with either unmet or partially met needs in each province or territory were reported. **Other notes:** • Rates per 100,000 were not available. Percentages were therefore used.
3.2	Percentage of youth aged 12-24 with early MHASU needs who accessed community-based mental health and substance use services in the last 6 months	**Data Source:** • Canadian Institute for Health Information. (2022). Common Challenges, Shared Priorities – Measuring Access to Home and Community Care and to Mental Health and Substance Use Services in Canada. (2022). Available via: https://www.cihi.ca/sites/default/files/document/common-challenges-shared-priorities-vol-4-report-en.pdf **Analytic Notes:** • The proportion of children and youth with self-reported early needs who accessed mental health and substance use services by provinces and territories was reported. The total number of respondents was multiplied by the percentage to determine the N of individuals represented. Data were missing for NL, PEI, and the territories.
3.3	Number of psychiatrists in Canada per 100,000 population	**Data Source:** • Canadian Medical Association, Psychiatry Profile. (2019). Available via: CMA Physician Workforce Survey **Analytic Notes:** • The total number of psychiatrists per province or territory, per 100,000 people was reported.
3.4	Supply of MHASU healthcare providers	**Data Source:** • Canadian Institute for Health Information. (2021). Available via: A profile of selected mental health and substance use health care providers in Canada, 2021. **Data notes:** • The number of MHASU healthcare providers per 100,000 across provinces and territories was reported.

Indicator	Indicator Category
3.5 30-day hospital readmission rates for MHASU concerns (2021-2022)	**Data Source:** • Canadian Institute for Health Information. (2023). 30-Day Readmission for Mental Health and Substance Use. Available via: https://www.cihi.ca/en/indicators/30-day-readmission-for-mental-health-and-substance-use **Analytic Notes:** • Using the number of readmissions for MHASU within 30 days of discharge after the index episode (Numerator), and the total number of episodes of care for a MHASU disorder discharged during the same period - the crude rate per province or territory was ascertained and reported. Data were cleaned using SAS 9.4.
4.1 Percentage of population reporting poor-to-fair mental health in core housing need (2021)	**Data Source:** • Statistics Canada. (2024). Canadian Housing Survey: Public Use Microdata File. Available via: https://www150.statcan.gc.ca/n1/en/catalogue/46250001 **Analytic Notes:** • Data were restricted to individuals with "fair or poor" mental health status. Core housing need was stratified by provinces or territories using cross tabulation techniques to determine those with MHASU in core housing need. Data were analyzed using SPSS, and percentages were reported. **Other Notes:** • Definition of Core housing need: *A household is in core housing need if its housing fails to meet at least one of three standards established for housing adequacy, suitability, and affordability, and it would have to spend 30% or more of its total before-tax income to pay the median rent of alternative local housing that is acceptable (meets all three housing standards).* (Statistics Canada, 2024).
4.2 Poverty rate (Market Basket Measure)	**Data Source:** • Statistics Canada. (2022). Disaggregated trends in poverty from the 2021 Census of Population. Available via: https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-X/2021009/98-200-x2021009-eng.cfm *(for provinces)* • Statistics Canada. (2022). Technical paper for the Northern Market Basket Measure of poverty for Yukon and the Northwest Territories. Available via: https://www150.statcan.gc.ca/n1/pub/75f0002m/75f0002m2022004-eng.htm *(for territories)* **Analytic Notes:** • Percentage estimates of the Market Basket Measure (MBM) were reported for provinces and territories.

Indicator	Indicator Category
4.3 Employment rate for individuals with mental health disabilities (ages 25-64)	**Data Source:** • Statistics Canada. (2024). Labour force status for persons with disabilities aged 25 to 64 years, by disability type (grouped). Available via: https://www150.statcan.gc.ca/t1/tbl1/en/cv.action?pid=1310073001 **Analytic Notes:** • The employment rate of individuals with mental health disabilities between the ages of 25 to 64 was reported by provinces and territories.
5.1 Percentage of people with poor-to-fair mental health who experienced discrimination and victimization	**Data Source:** • Statistics Canada. (2024). General Social Survey 2019, Canadians' Safety (Victimization): Public Use Microdata File. Available via: https://www150.statcan.gc.ca/n1/en/catalogue/45250001 **Analytic Notes:** • The data were restricted to individuals that self-reported their mental health as either "fair" or "poor." Data were then stratified by provinces or territories, and rates of discrimination for mental health were reported. Data were analyzed using SAS 9.4.
5.2 Percentage of population with poor-to-fair mental health who report feeling a stronger sense of belonging to community	**Data Source:** • Statistics Canada. (2024). General Social Survey, Social Identity (2020): Public Use Microdata File. Available via: https://www150.statcan.gc.ca/n1/pub/45-25-0001/index-eng.htm#a6 **Analytic Notes:** • The data were restricted to individuals that self-reported their mental health as either "fair" or "poor." Data were then stratified by provinces or territories, and the percentages of individuals that indicated a sense of belonging to their community as either "somewhat strong" or "very strong" were reported. Data were analyzed using SPSS.
5.3 Rate of police-Reported drug offences	**Data Source:** • Statistics Canada. (2022). Police-Reported Crime for Select Drug Offences, by Province or Territory, 2021. Available via: https://www150.statcan.gc.ca/n1/pub/85-002-x/2022001/article/00013/tbl/tbl08-eng.htm **Analytic Notes:** • The rate and number of total police-reported drug offences (i.e., including possession, trafficking, production, and importation or exportation) of all drugs (i.e., cannabis, cocaine, methamphetamine, ecstasy, opioids, heroin, and other drugs) were reported.

APPENDIX C:

ASSESSMENT GRID FOR POLICY INDICATORS

Indicator	Assessment Scale				
1.2 Mental health, addictions and substance use (MHASU) Strategy	**Ins.**	**Out of date**	**Somewhat comprehensive**	**Moderately comprehensive**	**Highly comprehensive**
	Insufficient information	Strategy is out of date	Active strategy but may have limited or no information about goals, accountability, and funding	Active strategy but may only provide moderate information about goals, accountability, and funding	Active strategy that has robust details on goals, accountability, and funding
1.3 Decriminalization policy (federal only)	**Ins.**	**Low support**	**Moderate support**	**High support**	**Very high support**
	Insufficient information	No federal *de jure* legislation but allows provincial, territorial or municipal *de jure* exemptions on case-by-case basis	Federal *de jure* legislation with high sanctions	Federal *de jure* legislation with moderate sanctions	Federal *de jure* legislation with minimal sanctions
1.4 Harm reduction policy • *Naloxone* • *Supervised consumption services (SCS) / overdose prevention services (OPS), Consumption and Treatment Services (CTS)* • *Drug Checking* • *Safer Supply*	**Ins.**	**Low support**	**Moderate support**	**Moderate-to-high support**	**High support**
	Insufficient information	P/T government supports one of the harm reduction interventions (naloxone, SCS/OPS/CTS, drug checking, or safer supply)	PT government supports two harm reduction interventions	P/T government supports three harm reduction interventions	PT government supports four harm reduction interventions
1.5 Mental Health Acts	**Ins.**	**Low concern**	**Moderate concern**	**High concern**	**Very high concern**
	Insufficient information	Low or no human rights concerns or complaints;	Some human rights concerns or complaints; Act may need review/amendment	Higher number of human rights concerns or complaints; Act in need of review/amendment	Unusually high number of concerns or complaints; Act in need of review/amendment

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