Canadian Mental Health Association
Mental health for all

Association canadienne pour la santé mentale
La santé mentale pour tous

Overpromised, Underdelivered

Analysis of Mental Health Care Investments in the 2023 *Working Together* Health Bilateral Agreements

August 2024

Overpromised, Underdelivered:

Analysis of Federal Mental Health Care Investments in the 2023 *Working Together* Health Bilateral Agreements

August 2024
Canadian Mental Health Association

This report was researched, written and prepared by SM Leduc, with contributions from Dr. Mary Bartam, Deb Wise Harris, Dr. Leyna Lowe, and Ammar Adenwala.

Suggested citation:

Leduc, SM. (2024). *Overpromised, Underdelivered: Analysis of Federal Mental Health Care Investments in the 2023 Working Together Health Bilateral Agreements*. Toronto, ON: Canadian Mental Health Association.

For media inquiries, contact:

Emma Higgins
National Manager, Communications & Media Contact
ehiggins@cmha.ca

ABOUT THE CANADIAN MENTAL HEALTH ASSOCIATION

Founded in 1918, the Canadian Mental Health Association (CMHA) is the most established, most extensive community mental health network of not-for-profit organizations in Canada. Through a presence in more than 330 communities across every province and the 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. Learn more: www.cmha.ca.

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.

EXECUTIVE SUMMARY

Instead of permanently funding a Canada Mental Health Transfer committed through the mental health and addictions ministerial mandate letter, the federal government under Prime Minister Justin Trudeau negotiated bilateral deals with each province and territory towards meeting the mental health care needs of Canadians.

The ten-year, $25 billion Working Together to Improve Health Care in Canada bilateral agreements were signed with the provinces and territories in 2023, with common measurement indicators and other accountability conditions. While mental health care was one of four target areas for funding through the bilateral agreements, there was no obligation for jurisdictions to dedicate new funding to mental health, addictions, or substance use services.

The Trudeau government has increasingly used bilateral agreements as a policy tool to bring forward ambitious policy agendas. Even so, the choice to pivot to new health bilateral agreements was puzzling: similar ten-year bilateral agreements covering mental health and substance use services were already in place from 2017, which also contained accountability measures via nationally comparable metrics around access, wait times, and other mental health care system outcomes aimed at informing—and improving—how mental health care is delivered.

In this report, the Canadian Mental Health Association sought to identify how much new federal money through the *Working Together* agreements is going toward mental health services, and whether there is a funding shortfall between the commitment to the mental health transfer and actual investments through the agreements. Our analysis also considers the efficacy of bilateral agreements as a mechanism to fund and address critical challenges in the mental health, addictions and substance use health care system.

MAIN FINDINGS

1

On average, only 15% of the 2023 *Working Together* investment is going to mental health care, with Yukon, spending 65.84% on mental health services, a significant outlier raising the average. This is quite different from federal claims that on average over 30% of these investments are for mental health. In fact, the median percentage of new federal money is just 5.7%. Manitoba and PEI are not using any bilateral dollars for mental health services, while BC is spending 0.01%.

2

There is a $1.6 billion dollar shortfall between the promised Canada Mental Health Transfer and actual mental health care expenditures through the 2017 and 2023 bilateral agreements. The shortfall rises to $2.2 billion in 2027-2028, when the remaining 2017 bilateral funding expires.

3

Despite commitments to targeted reforms in healthcare service delivery, it is questionable if bilateral agreements are an effective policy tool for meeting the mental healthcare needs of Canadians. The time limited nature of bilateral agreements means they are not an appropriate mechanism for addressing the structural exclusion of mental health, addiction, and substance use services from the *Canada Health Act*.

4

Addiction health services and health human resourcing were the main areas of investment identified by provinces and territories in their *Working Together* action plans. This includes increasing the supply of first responders, crisis responders, psychologists, psychiatrists, peer supporters, social workers, and other mental health professionals.

5

The lack of detail within the *Working Together* action plans makes it difficult to determine whether funding was intended for public, private, or not-for-profit delivery of programs and services, including community services that are instrumental in reducing strains on hospitals, shelters, and the criminal justice system.

6

Data on mental health and addictions are inconsistent across the country. Federally imposed indicators may not reflect how provinces and territories collect data or consider regional differences or priorities. Additionally, governments may not be fully addressing challenges to the healthcare system because data on community-delivered services are either overlooked or not measured.

Based on these findings, the Canadian Mental Health Association offers the following recommendations for federal action, which are fully articulated in the report.

RECOMMENDATION 1

Address the legislative exclusion of mental health services by either amending the *Canada Health Act* to explicitly include mental health and substance use health care services, or create parallel mental health and substance use healthcare legislation that include robust accountability measures and, at a minimum, adheres to the principles of public administration, comprehensiveness, universality, portability, and accessibility.

RECOMMENDATION 2

Permanently and responsibly fund mental health, addiction, and substance use services equivalent to 12% of provincial/territorial health care spending. Compared to our international peers that spend 12–14% of their health care dollars on mental health, addiction, and substance use health services are chronically underfunded in Canada because most are not covered by Medicare.

RECOMMENDATION 3

Ensure community-delivered mental health and addiction services receive funding by earmarking 50% of federal funding for mental health care delivered by community-based agencies.

RECOMMENDATION 4

Include care that is delivered by community agencies in the collection of health data by providing funding for the Canadian Mental Health Association to pilot a performance measurement framework for a common set of community mental health, addictions, and substance use health indicators that can be scaled up across the country.

RECOMMENDATION 5

Work collaboratively with provinces and territories, to strengthen the collection of nationally comparable, consistent data to measure health outcomes.

INTRODUCTION

In the mental health and addictions ministerial mandate letter (2021) Prime Minister Justin Trudeau committed to expand the delivery of accessible and free mental health services by establishing a new, permanently funded Canada Mental Health Transfer to provinces and territories.[1]

However, by 2023, the government had changed direction and negotiated individual 10-year bilateral health funding agreements with each province and territory, focused on four federally identified target areas[2], including mental health. The $25 billion *Working Together to Improve the Health Care in Canada* agreements included accountability conditions but did not require jurisdictions to dedicate funding to mental health, addictions, or substance use health services.

In this report, the Canadian Mental Health Association assesses whether the *Working Together* agreements achieve a similar impact to the promised transfer. To do so, this analysis aims to:

- Highlight mental health, addictions, and substance use health priority areas identified by each province and territory— including funding for community-delivered services— and describe trends across the country.
- Identify any shortfall in federal funding from the commitment to a mental health transfer to the actual investments in mental health, addictions, and substance use health care in the *Working Together* agreements.
- Determine the efficacy of bilateral agreements as a mechanism to fund and address critical challenges in the mental health care system.

BACKGROUND:

HOW MENTAL HEALTH IS FUNDED AND DELIVERED IN CANADA

Constitutionally, provinces and territories are responsible for delivering health care services, and for covering 78% of the cost of health care. The federal government provides the rest through the Canada Health Transfer.[3] For 2024-2025, the federal government will provide $52.1 billion to the provinces and territories through the Canada Health Transfer.[4]

Funding distributed through the Canada Health Transfer is conditional in that it must be spent on health. The *Canada Health Act* specifies which criteria the provinces and territories must respect to receive funding, as well as how and which health services are to be covered under public health insurance.

Under the *Canada Health Act*, federal health transfers fund only mental health, addictions, and substance use (MHASU)[5] services deemed "medically necessary."[6] Provincial and territorial health insurance plans are not required to insure MHASU services that fall outside this scope.

> Most MHASU services are covered only if they are delivered by physicians or in hospitals.

What that means, both in principle and practice, is that most MHASU services are covered only if they are delivered by physicians or in hospitals. A province or territory may fund services delivered by a third-party provider, such as private agencies or practitioners, or not-for-profit agencies, but they are not obliged to do so.[7]

This leaves the 6.5 million Canadians who do not have a family doctor mainly without funded services. In addition, when a person is treated in hospital, they are often discharged without adequate services in the community to support their recovery.

The mental healthcare system is in fact a patchwork: partial public funding stitched together with services that are not covered. Services that are not funded are delivered by private insurance or employer benefits, and not-for-profit organizations and include psychotherapy and counseling, substance use, addiction and eating disorder treatments, and social work (including case management).

Given not-for profit services are limited, Canadians most often pay out of pocket to receive MHASU supports if they do not have private coverage. This means only some will get the care they need. Many others will cycle through hospitals, shelters, and the criminal justice system without receiving that care.

STATE OF PLAY:

MENTAL HEALTH FUNDING AND BILATERAL FEDERALISM

To fully understand how the federal government arrived at the negotiating table for the 2023 health accords it's important to provide background on the evolving state of intergovernmental funding talks, set against this government's ambitious social policy agenda.

2015

The current Liberal government came to power in 2015 with a broad social policy agenda, including in areas under provincial and territorial jurisdiction, such as mental health, early learning and childcare, pharmacare, housing, and labour market workforce development. While national accords were used by previous governments to finance and promote health system reform, the Trudeau government moved away from that approach and leaned into bilateral agreements—that is, separately with each province and territory—as the preferred policy instrument to exercise federal spending powers.

2016

Prime Minister Trudeau inherited the tail-end of a 10-year health accord negotiated in 2004 under Liberal Prime Minister Paul Martin, and changes to the Canada Health Transfer's funding formula made under Conservative Prime Minister Stephen Harper that were set to expire in 2017. It was an opportunity to bring forward a new plan for healthcare reform, including attaching conditional, targeted spending. This approach, however, was more directive and less collaborative, as the federal government largely defined, and imposed, the policy vision and priorities.[8] Talks to negotiate a new national health accord with Premiers broke down this same year.

2017

The federal government proposed new health agreements that would be negotiated bilaterally, culminating in the *Common Statement of Principles on Shared Health Priorities.*[9] These new agreements meant that to unlock their share of $11 billion in federal funds, the provinces and territories had to specify where and how the money would be spent.[10] $6 billion was allocated for home and community care, and $5 billion for mental health and addiction services. The provinces and territories were also required to report on nationally comparable indicators to measure outcomes.[11]

2020

In 2020, the first wave of the novel coronavirus hit Canada, resulting in public lockdowns and limited access to in-person MHASU services. The pandemic strained the already-overstretched mental health sector and its workforce and laid bare the inadequate funding and system of care Canadians relied on for their mental health care needs.[12] Meeting the moment, the Liberals' 2021 election platform pledged to establish a permanently funded Canada Mental Health Transfer to expand the delivery of accessible and free mental health services, including for mental illness prevention and treatment.[13] The federal government's health reform agenda promised an initial investment for the transfer of $4.5 billion over 5 years starting in 2021-2022.

The pandemic strained the already-overstretched mental health sector and its workforce and laid bare the inadequate funding and system of care Canadians relied on for their mental health care needs.

2021

Following the 2021 election, the federal government reiterated its commitment to mental health by creating a new cabinet position for mental health and addictions and by directing the establishment of the Canada Mental Health Transfer in the Minister's mandate letter.[14]

2022

A dispute between the federal government and the Premiers[15] erupted over the complexities of cost-sharing arrangements for public healthcare through the Canada Health Transfer funding formula, overshadowing negotiations on the promised mental health transfer, and other healthcare reforms.

2023

A health summit was held in Ottawa resulting in the offer of an unconditional $2 billion federal top-up and a guaranteed increase to the Canada Health Transfer, as well as $25 billion over 10 years for new bilateral agreements. Like the 2017 bilateral agreements, the new bilateral agreements would be conditional on sharing and promoting health data as a public good. The *Working Together to Improve Health Care in Canada agreements* included four federal priorities: expand family health services, address the healthcare workforce supply, increase access to mental health and substance use services, and modernize health data.

When the 2023 agreements were being negotiated, four years of funding remained from the 2017 bilateral agreements for home and community care and mental health and addiction services. These dedicated funds for mental health were added to the new 2023 bilateral agreements[16] and were locked in: provinces and territories were obliged to spend them on MHASU services. *Working Together* action plans for three years of funding (2023-2024 to 2025-2026) were finalized with all provinces and territories by March 2024.[17]

BY THE NUMBERS

The federal government claims that on average over 30% of bilateral agreement investments are dedicated to MHASU.[18] However, this figure could be considered misleading: The government is likely calculating MHASU spending from both the 2017 and the 2023 agreements, and as such is not detailing how much of this money is new. To put it plainly, CMHA wanted to understand if provinces and territories are using 2023 federal bilateral dollars into MHASU over and above what they received in the 2017 agreement.

Table 1 shows the total new federal money for MHASU by breaking down federal funding from the 2023 bilateral agreements and what remains from the 2017 bilateral agreements.[19]

TABLE 1: NEW FEDERAL MONEY TO MENTAL HEALTH, ADDICTION, AND SUBSTANCE USE HEALTH CARE

P/T	A: REMAINING 2017 BILATERAL DOLLARS EARMARKED FOR MHASU *(2023-2026)*	B: TOTAL WORKING TOGETHER 2023 BILATERAL DOLLARS *(2023-2026)*	C: TOTAL MHASU SPENDING IDENTIFIED BY P/Ts IN WORKING TOGETHER *(2023-2026)*	D: TOTAL OF NEW MONEY FOR MHASU *(2023-2026)*	E: PERCENTAGE OF NEW MONEY FOR MHASU
BC	245,940,000 $	975,990,000 $	246,000,000 $	60,000 $	0.01%
AB	210,060,000 $	855,450,000 $	426,000,000 $	215,940,000 $	25.24%
SK	55,245,000 $	335,520,000 $	81,600,000 $	26,355,000 $	7.85%
MB	65,160,000 $	368,820,000 $	65,100,000 $	(60,000) $	0.00%
ON	698,610,000 $	2,496,180,000 $	1,293,687,000 $	595,077,000 $	23.84%
QC	398,400,000 $	1,488,000,000 $	N/A[20]	N/A	N/A
NFLD	24,330,000 $	154,440,000 $	48,950,000 $	24,620,000 $	15.94%
NS	47,160,000 $	308,340,000 $	58,029,000 $	10,869,000 $	3.53%
NB	37,560,000 $	276,090,000 $	46,200,000 $	8,640,000 $	3.13%
PEI	7,890,000 $	86,520,000 $	7,800,000 $	(90,000) $	0.00%
YK	2,010,000 $	21,810,000 $	16,370,364 $	14,360,364 $	65.84%
NWT	2,100,000 $	22,080,000 $	9,450,000 $	7,350,000 $	33.29%
NU	2,343,450 $	21,300,000 $	2,623,300 $	279,850 $	1.31%
			TOTAL FOR 2023-2026	**903,401,214 $**	**Average: 15%** **Median: 5.7%**

Provinces and territories are required to spend funding carried over from the ten-year 2017 bilateral agreement explicitly on MHASU services, those funds having already been committed under federal budgets 2017[21] and 2022.

However, although the federal government identified four priority areas in the 2023 agreements, provinces and territories were not compelled to spend specific amounts in those priority areas. This means jurisdictions were under no obligation to dedicate any new funding to mental health and substance use health services.

Indeed, PEI and Manitoba do not intend to spend new federal funding from the 2023 agreement on MHASU health care in their 2023-24 to 2025-26 action plans. To the extent that MHASU initiatives and funding are outlined in their respective 2023 action plans, these are carried over from the 2017 bilateral agreements. Note that in Table 1, PEI and Manitoba have negative values for MHASU. This is because they are using 2017 dollars to fund non-MHASU initiatives.

Jurisdictions had flexibility to allocate funding to four target areas within their *Working Together* action plans, two of which were expanding family health services and increasing access to mental health and substance use services. While funding to expand family health services could at times include increasing MHASU services, the action plans did not provide enough detail or costing to accurately include them in Table 1. As such, the table only considers funding specifically identified under the target area of "increasing access to mental health and substance use services."

Jurisdictions were under no obligation to dedicate any new funding to mental health and substance use health services.

Excluding Québec (because those figures are not available), the total new money for MHASU in the first three years of the *Working Together* bilateral agreements is approximately $903 million, or $301 million annually.

After excluding the portion of funding allocated to Québec, the median percentage of new federal money for MHASU is 5.7%; the average is 15%, with Yukon (at 65.84%) raising the mean as a significant outlier.

Having determined which 2023 *Working Together* investments were new (Table 1, Column D), the annual shortfall between the promised transfer and the actual MHASU expenditures in the agreements became starkly apparent. Even taking together MHASU investments in the 2017 and the 2023 bilateral agreements, the level of funding falls far short of the commitment of a mental health transfer. Table 2 demonstrates that the shortfall is nearly $1.6 billion, annually, starting in 2026-2027, rising to $2.2 billion in 2027-2028, after the remaining 2017 bilateral funding expires.

TABLE 2: ANNUAL INVESTMENT SHORTFALL BETWEEN THE PROMISED CANADA MENTAL HEALTH TRANSFER AND THE ACTUAL MENTAL HEALTH, ADDICTION, AND SUBSTANCE USE HEALTH CARE EXPENDITURES THROUGH BILATERAL AGREEMENTS

	Fiscal 2023-2024	Fiscal 2024-2025	Fiscal 2025-2026	Fiscal 2026-2027	Fiscal 2027-2028
Remaining funding from the 2017 bilateral agreement earmarked for MHASU	$600M	$600M	$600M	$600M	$0
Government's promised Canada Mental Health Transfer[22]	$625M	$1B	$2B	$2B	$2.5B[23]
Promised expenditures	**$1.225B**	**$1.5B**	**$2.5B**	**$2.5B**	**$2.5B**
Remaining funding from the 2017 bilateral agreement earmarked for MHASU	$600M	$600M	$600M	$600M	$0
New money for MHASU in 2023 bilateral agreement	$301M	$301M	$301M	$301M	$301M[24]
Actual expenditures	**$901M**	**$901M**	**$901M**	**$901M**	**$301M**
Shortfall (Promised, minus actual)	**$324M**	**$599M**	**$1.599B**	**$1.599B**	**$2.199B**

TRENDS IN MENTAL HEALTH AND ADDICTION SERVICE INVESTMENTS IN THE 2023 BILATERAL ACTION PLANS

Tables 3 and 4 show an overview of the specific areas of investment in MHASU identified in the three-year bilateral action plans (2023–2024 to 2025–2026). Given the asymmetrical agreement between the governments of Canada and Québec, no specific priorities are identified in Québec's action plan.

TABLE 3: PRIORITY AREAS IN MENTAL HEALTH, ADDICTIONS, AND SUBSTANCE USE HEALTH CARE

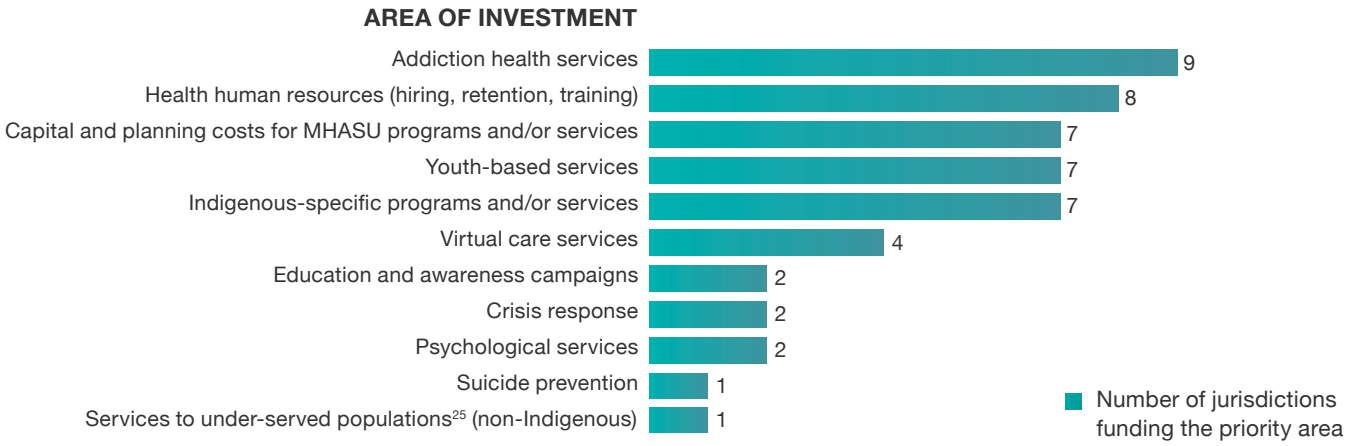

TABLE 4: PRIORITY AREAS IN MENTAL HEALTH, ADDICTIONS, AND SUBSTANCE USE HEALTH CARE BY JURISDICTION

AREA OF INVESTMENT	BC	AB	SK	MB	ON	NFLD	NS	NB	PEI	YK	NWT	NU
Addiction health services	X	X	X	X		X	X	X		X	X	
Health human resources (hiring, retention, training)			X	X		X	X	X	X	X		X
Capital and planning costs for MHASU programs and/or services			X	X	X	X	X			X		X
Youth-based services	X	X	X		X		X		X	X		
Indigenous-specific programs and/or services	X	X	X	X	X			X		X		
Virtual care services	X					X					X	X
Education and awareness campaigns										X		X
Crisis response			X						X			
Psychological services				X	X							
Suicide prevention											X	
Services to under-served populations (non-Indigenous)							X					

KEY TRENDS IN THE *WORKING TOGETHER* ACTION PLANS

The top two priority areas identified by jurisdictions in their respective *Working Together* action plans are addiction health services and health human resourcing.

Nine of the 12 reporting jurisdictions highlight addiction health services. This is a significant increase from the original 2017 bilateral agreement action plans, where only three jurisdictions identified addiction services. From the 2023 agreements, New Brunswick and Yukon and Northwest Territories are focusing on managed alcohol or alcohol withdrawal programs; BC, Alberta, Saskatchewan, Manitoba, and Yukon and Northwest Territories are increasing treatment spaces/beds or building capacity.

Mirroring similar challenges within the broader health care system, jurisdictions are seeking to bolster the health human resource needs of the MHASU health care sector—such as hiring, recruitment, retention, and upskilling or training. Eight of the 12 reporting jurisdictions will increase staffing in areas like police and crisis response, psychology, psychiatry, peer support, social work, and other mental health specialties. Several jurisdictions also highlighted the need for more specialized training in MHASU for primary care workforce.[26]

Mirroring similar challenges within the broader health care system, jurisdictions are seeking to bolster the health human resource needs.

Another priority area identified by most reporting jurisdictions (7 of 12) is capital and planning costs for MHASU programs and/or services. Initiatives in this category include implementing reporting outcome tools, decreasing wait times for services, building data infrastructure, and enabling the creation of community wellness plans.

Focus on programs and services aimed at youth and Indigenous populations also substantially increased between the 2017 and 2023 agreements, with seven of 12 of the reporting jurisdictions identifying initiatives in each category. Action plans predominately featured school-based programs and social and emotional learning, as well as help for parents and families at risk of interactions with child and family services. Land-based healing projects and culturally relevant services topped the Indigenous-specific initiatives.

While not identified as a distinct category in Table 3, Saskatchewan, Ontario, Newfoundland and Labrador, PEI, and Yukon are all investing in mobile services —like purpose-built medical vehicles, field teams, or pairing mental health and addiction specialists with police or other emergency providers—to support homeless populations and individuals in mental health distress. The action plans highlight the cost-effectiveness of mobile services, the ability to treat individuals ‘where they’re at’, and diversion from expensive or unnecessary settings like hospitals or the criminal justice system.

ACCOUNTABILITY

This section provides an overview of the specific MHASU-related indicators in the 2017 and 2023 bilateral agreements and public reporting to date from the Canadian Institute for Health Information (CIHI), in addition to examining some challenges found in reporting the data. CIHI is the lead agency synthesizing and publicly reporting on the common and headline indicators in the agreements.

TABLE 5: 2017 *COMMON STATEMENT ON PRINCIPLES* INDICATORS

The proportion of individuals aged 13 to 24 with early mental health and substance use needs who accessed community-based mental health and substance use services in the last 6 months.	2023.[27] Survey; non-probabilistic sampling.	**Canadian average: 73%** About half of children and youth with early needs said that MHSU services were not easy to access.	5: Results for Newfoundland and Labrador, Prince Edward Island, Yukon, the Northwest Territories and Nunavut not included due to insufficient data.
The proportion of individuals aged 15 and older who said that they always or usually had the support[28] necessary to move within and between formal mental health and substance use (MHSU) services in the past year once they accessed services.	2023.[29] Survey; non-probabilistic sampling.	**Canadian average: 44%** Two in 5 Canadians said they always or usually had support navigating MHSU services.	2: Results for Yukon and Nunavut are not included due to insufficient data.
The median number of calendar days clients waited for ongoing counselling services from the date that the initial referral was received to the date of the first scheduled counselling session.	2023.[30] Data comes from independent provincial and territorial systems	**Canadian average: 31 days** Half of Canadians wait about a month for ongoing counselling services in the community. One in 10 wait nearly five months.	5: No data is available for Prince Edward Island, Quebec, Ontario, the Northwest Territories and Nunavut.
How often people are admitted to hospital or die due to self-harm in a year.	2022.[31] Canadian Vital Statistics Death Database and Yukon Vital Statistics.	**Canadian average: 74 per 100,000** 24,400 Canadian were hospitalized or died by intentionally harming themselves in 2021.	All jurisdictions reporting.

INDICATOR	CIHI REPORT DATE	KEY FINDINGS	JURISDICTIONS THAT DID NOT REPORT DATA
How many hospital stays in a year are a direct result of using alcohol, cannabis and other substances.	2023.[32]	**Canadian average: 522 per 100,000** Four in 10 adults (25+) and seven in 10 children and youth (10-24) who are hospitalized for harm caused by substance use also have a mental health condition such as anxiety, depression, or schizophrenia.	All jurisdictions reporting, though Québec's data is from 2021-2022.
Percentage of Canadians that frequently visit an emergency room (at least four times a year) for help with mental health and substance use	2022.[33]	**Canadian average: 9.4%** Nearly one in 10 Canadians who visit the ER for help with mental health and substance use have 4+ visits a year.	5: No data is available for Newfoundland and Labrador, New Brunswick, the Northwest Territories and Nunavut; there are also no results for Manitoba due to insufficient data coverage.

TABLE 6: 2023 *WORKING TOGETHER* HEADLINER INDICATORS[34]

	BC	AB	SK	MB	ON	QC[35]	NFLD	NS	NB	PEI	YK	NWT	NU
INDICATOR	**Median wait times for community mental health and substance use services.[36]**												
Baseline	15 days	19 days	12 days	Under development	N/A		33 days	22 days	62 days	Data unavailable	6 days	4 days	Data unavailable
Target	14 days	17 days	11 days	Under development	Adult: 103 days Youth: 62 days[37]		32 days	20 days	55 days	Data unavailable	5 days	4 days	Data unavailable
INDICATOR	**The percentage of youth aged 12 to 25 with access to integrated youth services (IYS) for mental health and substance use.**												
Baseline	15 sites	N/A	0 sites	6 sites	22 sites		1 site	1 site	0 sites	N/A	N/A	1 site	N/A
Target	20 sites	N/A	3 sites	6 sites	27 sites		At least 2 sites	8 sites	3 sites	N/A	N/A	1 site	N/A
INDICATOR	**The percentage of Canadians with a mental disorder who have an unmet mental health care need.**												
Baseline	8%	8.7%	7%	8%	7%		6%	10%	6%	7%	Data unavailable	Data unavailable	Data unavailable
Target	7%	7%	6.3%	7%	TBD[38]		5%	9%	6%	7%	Data unavailable	Data unavailable	Data unavailable

INDICATORS:
CAVEATS AND CHALLENGES

The 2017 and 2023 performance indicators are not intended to measure the outcomes of each specific MHASU service identified by the jurisdictions.

The bilateral agreements clearly state that the evaluation of programs and services rests with the jurisdictions in keeping with their respective evaluation policies and practices; that also includes what they report publicly to their residents.

However, jurisdictions are required to report quarterly to the federal government on how federal bilateral funds are managed and spent, as well as participate in a CIHI-led Federal-Provincial-Territorial data collection process. That's because one of the federal government's rationales for bilateral agreements was the desire for better, nationally comparable data to inform—and improve—health care outcomes.

The management and stewardship of health information are overseen by thirteen different jurisdictions in Canada, making it challenging to harmonize data. How and why jurisdictions collect data varies widely and regional-specific considerations can affect what data is collected. In the territories, for instance, certain indicators are not yet measured because population sample sizes are too small to run data surveys without privacy risks.

Federal indicators may not reflect how jurisdictions measure data.

Federal indicators may not reflect how jurisdictions measure data. For instance, nearly all jurisdictions reported the number of active Youth Integrated Services (IYS) sites, but did not report the percentage of youth with access to these sites. Alberta is reporting the number of new specialized services or preventative programs available in schools.[39] In For another 2023 federal indicator, Manitoba did not provide some data on wait times for community mental health services because the existing CIHI baseline does not reflect current wait times in the province.[40]

In several other instances, jurisdictions may be reporting on similar, but not identical, data. "Median wait times for community mental health services" measures how long people wait for publicly funded counselling. However, Alberta is reporting wait times for mental health and substance use services more broadly.

Some jurisdictions are also pushing back against federal indicators, reflecting a reorientation of health care delivery and data collection within their jurisdictions. Alberta, for instance, notes that the 2023 headline indicators focus on outputs, such as service utilization, and do not effectively measure patient/client outcomes or experiences, or support early response to emerging issues.

All jurisdictions, therefore, included regional-specific indicators in their 2023 bilateral agreements that provide an interesting snapshot of the kinds of data that jurisdictions are measuring to improve their health and mental health care systems.

KEY FINDINGS:

A CALL FOR SUSTAINABLE FUNDING & ACCOUNTABILITY

Bilateral agreements are increasingly used by the federal government as a mechanism for social policy reform in areas of provincial and territorial responsibility, such as addressing gaps in MHASU services.

Bilateral agreements typically include conditions and accountability metrics to measure progress and understand need across Canada, showcasing how this federal government is heavily invested in transparency, data measurement, and evidence-informed decision-making. But are these bilateral agreements effective in meeting the mental healthcare needs of Canadians?

While a full analysis of the bilateral agreements' return on investment is outside the scope of this research, the following are key findings and recommendations that could help inform and strengthen a future federal policy agenda for Canada's mental health care system.

SUSTAINABLE FUNDING

One of the most important differences between the bilateral agreements and a Canada Mental Health Transfer is that funding in the agreements is time limited, while the Transfer would have been permanent.

Bilateral agreements perpetuate an approach in which Mental Health, Addictions, and Substance Use concerns are addressed through short-term programs and pilot projects.

Bilateral agreements are not adequately serious mechanisms to confront the crisis in our mental health care system. The mental health sector already struggles with capacity and programming obstacles, like interrupted funding that makes it difficult to hire and retain a stable workforce. Bilateral agreements perpetuate an approach in which MHASU concerns are addressed through short-term programs and pilot projects. They also create other risks: What happens to the ten-year funding beyond 2033, when the *Working Together* agreements expire? What if a future federal government is not seized by the challenges faced by the mental health care sector?

Permanent, responsible funding means provinces and territories are not obligated to pay for federal initiatives when time limited investments are not renewed[41], as was the case in the 1990s when federal deficit and austerity measures left federal priorities in health, housing and social assistance vulnerable.[42]

While the promised initial annual investment of $2.5 billion for a Canada Mental Health Transfer was welcomed by the mental health care sector, this sum should not be used as a benchmark. A $2.5 billion annual investment in MHASU would have been a start but would not sufficiently address the level of need for support and care across the country.

Further, a $2.5 billion transfer for mental health care would represent just 4.8% of what is transferred annually to provinces and territories through the Canada Health Transfer.[43] In terms of actual expenditures, Canada lags behind other countries in sustainable investments in MHASU, spending only 5-7% of overall healthcare budgets on mental health[44], whereas our OECD peer nations like France, New Zealand and the Netherlands spend somewhere between 10-13%[45].

RECOMMENDATION 1

That the federal government take steps to either amend the *Canada Health Act* to explicitly include mental health and substance use health care services, or that it create parallel mental health and substance use healthcare legislation that includes robust accountability measures.[46]

RECOMMENDATION 2

That the federal government commit to sustainable, predictable, and responsible funding for mental health and substance use health care equivalent to 12% of provincial/territorial health care spending.[47] This would represent a total annual investment of approximately $6.25 billion.

COMMUNITY MENTAL HEALTH SERVICES

This report not only intended to understand the amount of new funding for MHASU initiatives within the 2023 bilateral agreements, but also to determine how much new funding was being invested in community-delivered services. However, two issues hindered the second part of this analysis.

First, the lack of detail within the action plans made it difficult to break down whether funding was intended for public, private, or not-for-profit delivery of programs and services.

Second, and perhaps more importantly, how the government's talks about "community services" differs from how it is used in the not-for-profit mental health sector, in that the government seems to consider hospital out-patient services and a handful of other publicly funded supports as delivered in "community."

Community mental health services play an important role in filling the gaps in provincial and territorial health insurance plans. Community MHASU services are typically delivered by not-for-profit organizations that, at times, partner with family doctors, psychiatrists and hospitals, thereby complementing the primary care system and government-delivered health services. Inadequate funding for community agencies can lead to unsustainable pressures on emergency departments, paramedics, police departments, shelters, and the justice system.

RECOMMENDATION 3

That the federal government earmark 50% of federal funding for community-delivered mental health and substance use health care.

By overlooking community-delivered services, governments may not be fully addressing challenges to the healthcare system, such as the human resources needed to increase the number psychologists, social workers, specialized nurses, and other mental health professionals that provide frontline community services and provide acute and crisis care. Reforms to our health care system, including better data collection and management, must consider the full spectrum of how MHASU services are delivered.

By overlooking community-delivered services, governments may not be fully addressing challenges to the healthcare system, such as the human resources needed.

To illustrate, both the 2017 and 2023 bilateral agreements include a performance indicator measuring median wait times and timely access to community mental health counselling. However, this indicator includes only *publicly* funded services, meaning services that are provided, coordinated or overseen by a government. However, most psychological and counselling services are delivered outside of the publicly covered health system. The indicator therefore does not use a representative sample and its results do not provide a full picture of that service.

Performance measurement is key to identifying health outcomes and quality improvement. Broadly speaking, data within the community sector is inconsistently collected (when at all) and considered separately from acute and primary health data, making these data hard to compare across health sectors and jurisdictions. Without data, it is difficult to demonstrate the value of community mental health services or understand the real-time capacity, utilization, wait times, or outcomes of these services at a time when Canada's broader healthcare system is under strain.

RECOMMENDATION 4

That the federal government, through Health Canada, provide funding to the Canadian Mental Health Association to pilot and implement a performance measurement framework for a common set of community mental health, addictions, and substance use health performance indicators.

REPORTING AND ACCOUNTABILITY

Canada suffers from a lack of consistent, nationally comparable data to measure health outcomes and investments in health, as illustrated in this report's section on accountability indicators within the bilateral agreements,

Combined, the 2017 and 2023 bilateral agreements contain eight indicators specific to MHASU. It is unclear, however, whether Federal-Provincial-Territorial data sharing will extend beyond the ten-year bilateral time frame (2033). To make improvements to our mental healthcare system, though, we need consistent data.

RECOMMENDATION 5

That the federal government work with provinces and territories to strengthen the collection of quality and consistent data across a comprehensive set of indicators to better track system performance.

In 2022, CIHI published a report containing the full suite of indicators tied to the 2017 bilateral agreement. Much of that reporting contained caveats, noting that indicator data would continue to be refined and improved and initial results should thus be interpreted with caution.[48] Although CIHI's report came at the half-way point of the 10-year agreement, CIHI stated that the 2022 report would be the final companion report for the 2017 indicators project. Future results will only be shared through CIHI's indicator library, and not through a companion report.

Unfortunately, information in CIHI's indicator library[49] is difficult to navigate and download. Companion reports provide analyses of all the indicators in one location, as well as a fuller narrative containing historical context and trends over time. CMHA would like to see these companion reports return.

CONCLUSION

During Mental Health Week 2024, Prime Minister Trudeau stated that his government is, "… making sure that all Canadians have access to the mental health care they need, no matter where they live or what they do. That means making sure that mental health is a full and equal part of our health care system."[50]

Yet, as our analysis has shown, the *Working Together* agreements fail to make mental health an equal part of our healthcare system and fall far short of the promised Canada Mental Health Transfer.

When asked why it did not create the transfer, the federal government stated that Canadians would be best served by integrating mental health services (hiring mental health specialists) into primary health care.[51] However, this explanation is unconvincing given that jurisdictions were not required to spend the *Working Together* funding in this way.

With respect to data, even with attempts to fill critical mental health information gaps through the agreements, problems remain with data collection and quality, making it difficult to measure health outcomes and investments in health.

As a time-limited funding mechanism, bilateral agreements are vulnerable to political shifts and contribute to the funding instability routinely encountered in the MHASU health care system. Overall, despite commitments to targeted reforms in healthcare service delivery, the effectiveness of bilateral agreements as a policy tool is questionable. They will not meet the mental healthcare needs of Canadians. For mental health to be truly a full and equal part of our healthcare system, the federal government must move away from short-term bilateral agreements toward a more sustainable solution.

ENDNOTES

1 Ministerial mandate letters outline the objectives that each minister works to accomplish. Office of the Prime Minister of Canada. Minister of Mental Health and Addictions and Associate Minister of Health Mandate Letter. 2021.

2 The other areas are expanding family health services, addressing the healthcare workforce suppl, and modernizing health data.

3 Canadian Medical Association. How is Health Care Funded in Canada? 2024.

4 Government of Canada. Budget 2024: Stronger Public Health Care to Lift Up Every Generation. 2024.

5 CMHA uses the term 'mental health, addictions, and substance use' (MHASU) throughout this document. Addictions is a more comprehensive term that covers issues such as gambling or behavioural addictions that are not substance related. Further, not all substance use results in addictions.

6 See "What health care services are insured by the provinces and territories?" in Health Canada. Canada Health Act: Frequently Asked Questions. 2024.

7 For example, a province contracts out the delivery of counselling to a not-for-profit agency.

8 Peter Graefe and Nicole Fiorillo. The Federal Spending Power in the Trudeau Era: Back to the Future? Institute for Research in Public Policy. 2023.

9 Tom McIntosh and Alanna DeCorby. From National Accords to Bilateral Agreements: Transforming Canadian Health-Care Intergovernmentalism. The School of Public Policy Publications. 2022.

10 The governments of Canada and Québec entered into a new asymmetrical agreement based on the principles of the September 2004 Asymmetrical Federalism agreement that respects Québec's jurisdiction over health.

11 Health Canada. A Common Statement of Principles on Shared Health Priorities. 2018.

12 Leyna Lowe. Running on Empty. Canadian Mental Health Association. 2022.

13 Liberal Party of Canada. Forward for Everyone. Fiscal and Costing Plan. 2021.

14 Office of the Prime Minister of Canada. Minister of Mental Health and Addictions and Associate Minister of Health Mandate Letter. 2021.

15 Council of the Federation. Awareness Campaign to Improve Health Care for all Canadians. 2022.

16 The government also implemented separate "Aging with Dignity" bilateral agreements incorporating the funding for home and community care from the remaining 2017 bilateral agreements, as well as an additional $3 billion over five years for long-term care from Budget 2021.

17 Again, the governments of Canada and Québec entered into a new asymmetrical agreement based on the principles of the September 2004 *Asymmetrical Federalism* agreement that respects Québec's jurisdiction over health.

18 Open Parliament. Department of Health—Main Estimates, 2024-25. 29 May 2024.

19 Three-year action plans were signed for fiscal years 2023-2024, 2024-2025, and 2025-2026; as such, calculations can only consider funding from 2023-2026.

20 Given that the asymmetrical agreement between the governments of Canada and Québec did not contain a funding allocation breakdown for MHASU, it is not possible to include Québec in the total calculations.

21 Finance Canada. Table 3.2. Building a Stronger Middle Class: Budget 2017. 2017.

22 Liberal Party of Canada. Forward for Everyone. Fiscal and Costing Plan. 2021.

23 The Canada Mental Health Transfer would have been funded permanently. This report therefore makes certain assumptions, based on the Liberal campaign wording, that this new transfer would have been benchmarked at $2.5B annually beyond their 2026-2027 costing plan.

24 The 2023 bilateral agreements are currently signed for three years (2023 -2026), after which jurisdictions could amend their action plans and put more funding in MHASU services. Table 2 assumes the same funding of 301M annually is versed beyond 2026.

25 Under-served populations here mean black and/or racialized populations and linguistic minorities.

26 Nova Scotia, for instance, will develop an Advanced Practice in Mental Health and Addiction stream at the Dalhousie School of Nursing as part of the Master of Nursing degree. Interestingly, in November 2023 the College of Family Physicians of Canada reversed a decision to add a third year to family medicine residency focusing on mental health and addictions over concerns that the additional training would add to health human resource shortages; that decision was supported by Ministers of Health.

27 CIHI. Early Intervention for Mental Health and Substance Use Among Children and Youth. 2023.

28 Where support refers to receiving the guidance, assistance or resources needed to navigate MHSU services from a professional.

29 CIHI. Navigation of Mental Health and Substance Use Services. 2023.

30 CIHI. Wait Times for Community Mental Health Counselling. 2023.

31 CIHI. Self-Harm, Including Suicide. 2022.

32 CIHI. Hospital Stays for Harm Caused by Substance Use. 2023.

33 CIHI. Frequent Emergency Room Visits for Help with Mental Health and Substance Use. 2022.

34 Unless otherwise noted all indicator timeframes are for the 2025-2026 fiscal year.

35 Within the asymmetric 2017 and 2023 bilateral, Québec commits to collaborating with CIHI to share and develop comparable indicators as their internal data became available. That said, for the 2023 agreement, Québec did not provide information on indicator benchmarks or targets and instead referred to their public accountability dashboard on the performance of the health and social services system (Tableau de bord sur la performance du réseau de la santé et des services sociaux).

36 This indicator is a duplicate from the 2017 bilateral agreement common indicators.

37 Ontario's timeframe for this target is March 2024.

38 Ontario's timeframe for this target is March 2025.

39 Canada-Alberta Agreement to Work Together to Improve Health Care for Canadians (2023-24 to 2025-26).

40 Canada-Manitoba Agreement to Work Together to Improve Health Care for Canadians (2023-24 to 2025-26).

41 Premiers have expressed this concern as recently as their annual summer meeting in July 2024, stating in a joint press release that, "If federal funding ends, provinces and territories can end up footing the bill for federal programs." Council of the Federation. Premiers discuss ways governments can work together to better support Canadians. 17 July 2024.

42 Peter Graefe and Nicole Fiorillo. The Federal Spending Power in the Trudeau Era: Back to the Future? Centre of Excellence on the Canadian Federation. 2023.

43 For 2024-2025, the federal government will provide $52.1 billion to the provinces and territories through the Canada Health Transfer.

44 Mental Health Commission of Canada. Strengthening the Case for Investing in Canada's Mental Health System: Economic Considerations. 2017.

45 OECD. Making Mental Health Count. 2014.

46 Additionally new legislation should, at a minimum, adhere to the principles of public administration, comprehensiveness, universality, portability, and accessibility, as the *Canada Health Act* currently does.

47 CMHA's 12% target is in line with recommendations proposed by the Royal Society of Canada. Easing the Disruption of COVID-19: Supporting the Mental Health of the People of Canada. (2020)

48 CIHI. Common Challenges, Shared Priorities: Measuring Access to Home and Community Care and to Mental Health and Substance Use Services in Canada. 2022.

49 Canadian Institute for Health Information. Indicator Library.

50 Office of the Prime Minister of Canada. Statement by the Prime Minister on Mental Health Week. 2024.

51 Government of Canada. Standing Committee on Health. Evidence for Meeting 86, 44-1. 2023.