Running on empty

How community mental health organizations have fared on the frontlines of COVID-19

March 2022

Canadian Mental Health Association
Mental health for all

100 years of community

About CMHA

Founded in 1918, the Canadian Mental Health Association (CMHA) is the most established, most extensive community mental health organization in Canada. Through a presence in more than 330 communities across every province and one territory, CMHA provides advocacy and resources that help to prevent mental health problems and illnesses, support recovery and resilience, and enable all Canadians to flourish and thrive. For more information, please visit the CMHA website at www.cmha.ca.

The Canadian Mental Health Association National office is located in Toronto on the traditional and unceded territory of the Mississaugas of New Credit, the Haudenosaunee and the Huron-Wendat.

For more information, contact:

Sarah Kennell
National Director, Public Policy
416-646-5557 x24999
skennell@cmha.ca

Media Inquiries:

Katherine Janson
National Director of Communications
416-646-5557 x24923
kjanson@cmha.ca

Executive Summary

The pandemic has had a devastating impact on mental health, substance use and homelessness in Canada.[1] In 2021, the Canadian Mental Health Association (CMHA) undertook a federation-wide research project to understand how community mental health organizations have been impacted by and responded to the pandemic. Our research helped us formulate which federal policy responses are required so that community mental health organizations – and the people they serve – can get through and recover from the pandemic. Twenty-one participants representing 18 individual CMHA branches and/or divisions from 10 provinces and the Yukon territory were interviewed for this research, which was led by Dr. Leyna Lowe.

Our research indicates that the pandemic has:

- **Had devastating impacts on the mental health, substance use and homelessness of Canadians and highlighted the pre-existing and increasing needs for mental health, addiction and support services.**
- **Made visible the current patchwork system of care provided in the private, public and not-for-profit sectors. The vital mental health and addiction programs, services and supports delivered by not-for-profits are crucial and need to be better integrated.**
- **Laid bare the inadequate and unsustainable funding of not-for-profit mental health and addictions services delivered by charitable organizations**
- **Strained the already-overstretched community mental health sector and its workforce.**

Key findings from the research:

The pandemic has had devastating impacts on the mental health, substance use and homelessness of Canadians, and highlighted pre-existing and increasing needs for services.

- There is a significant and growing need for mental health and addiction services available through the not-for-profit and public sectors, including ongoing in-person and virtual counseling and psychotherapy.

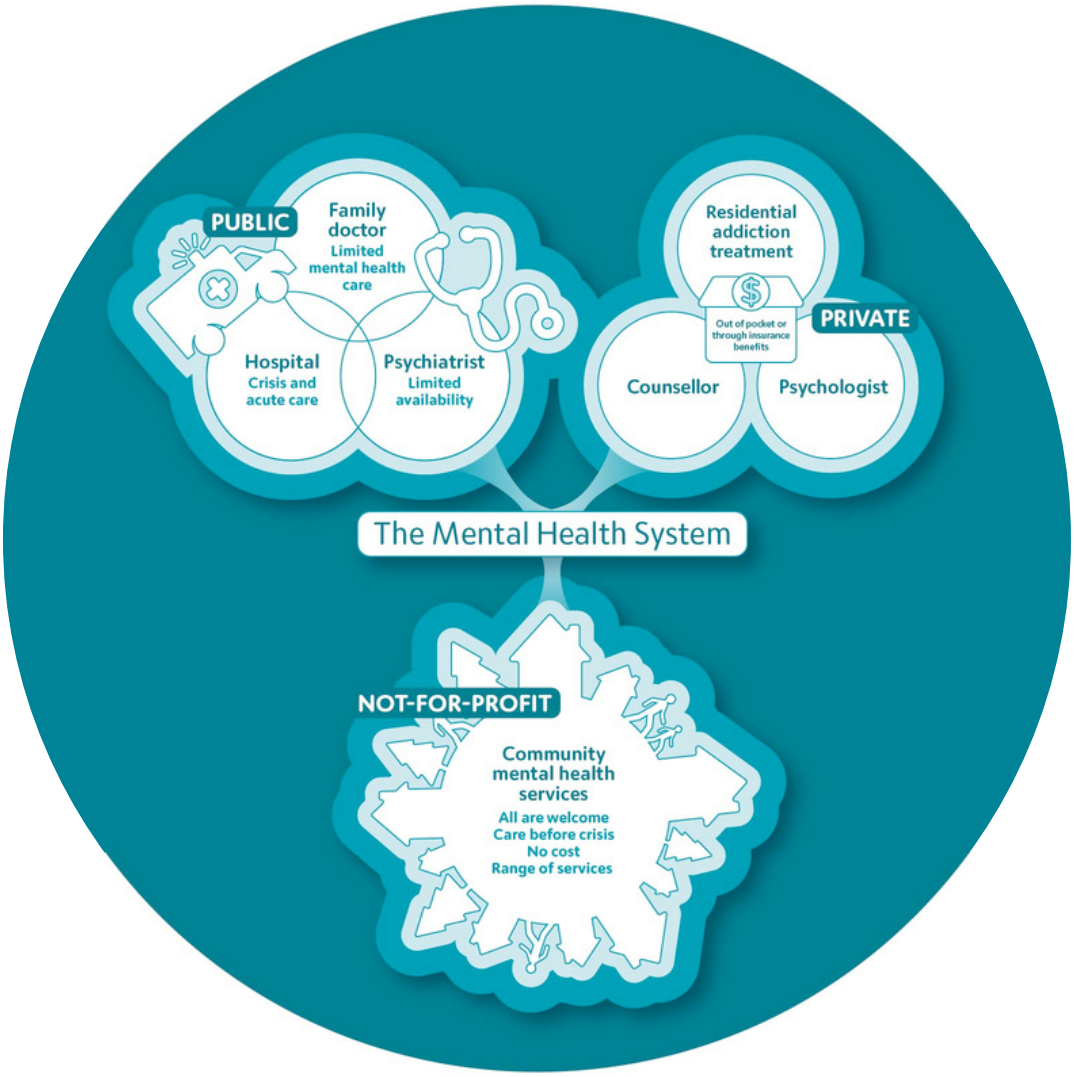
> *"We're finding that our waitlists are growing, the amount of time people are waiting for services is growing and the most significant area that that's happening is for counseling."*

"...actually securing a consistent, regular counselor of the kind that will actually help you, whereby you build a relationship with this person and they help you go through years of trauma, chronic illness and all, that's very, very difficult to find."

- Virtual mental health services have improved access to mental health services for some but are a barrier for those with limited access to technology, such as seniors and people who are low-income.

"We also heard that from folks who ... who have access to technology, that the transition to virtual services has benefited that population of people. Conversely, on the other side of the coin, transitioning to virtual services has actually created more barriers in access to mental health and addiction services for folks who are low income, who are more marginalized, who don't have access to, you know internet, computer, or telephone."

The current system of care is a patchwork of programs, services and supports offered by the private, public and not-for-profit sectors.



- The mental health and addiction programs, services and supports delivered by not-for-profit organizations are crucial and need to be better integrated.

> *"I think there could be some interesting work done in [...] how we move towards a more equal relationship between clinical governmental services and community-based mental health supports, because I think so long as they remain forever separated and never connecting, other than to refer to each other, people aren't necessarily going to get the type of support that they need."*
>
> *"I'm really tired of them [mental health and physical health] being disconnected. They are connected. We are a whole system body [...] it has to be much more holistic in our approaches to link things together. So not just have mental health over here, supports and community and diabetes over there. I think there has to be much more layering going on around community supports with mental health, connected to physical health as well...not separating [them] because it keeps the stigma going."*

The current funding of not-for-profit mental health and addiction services delivered by charitable organizations is inadequate and unsustainable.

- CMHAs feel that community mental health organizations are underfunded, as the provinces and territories currently dedicate only around 5-6% of overall healthcare spending to mental health and addictions, a portion of which goes to community mental health organizations.

> *"Because community mental health has been so underfunded, everything's kind of piecemeal...together, we get a little bit of funding here for this program, we get a little bit of funding here for this program, and then you're stuck in those kind of funding agreements [...]"*

- Short-term and emergency funding should be replaced by long-term, sustainable, core funding.

> *"It's these little pockets of money that are never enough to actually provide the service that is expected... contracts are always late, money never shows up on time, you're reporting on it, and then you're starting the next round of proposals again because the year is up. And it's very challenging to retain the quality employees in these programs when you can never promise them stability and it's really difficult to be strategic in your work and to make plans when you're year to year just trying to say, "how can I pay myself, my admin, how do I pay the rent, and how do I pay the team members when the dollars are never enough?"*

The community mental health system and its workforce are experiencing significant strain.

Due to chronic underfunding, many mental health and addiction workers receive lower wages, higher work demands, experience compassion fatigue, are exposed to trauma and are likely to experience burnout. These effects have intensified during the pandemic.

> *"It was, you know, a lot of stress, a lot of people felt that because we're a mental health organization and COVID happened that this was the time to push even harder. But that came at the expense of a lot of people who were already under stress from the pandemic themselves and in their own personal lives, then feeling it as a professional in mental health that you need to now work overtime, I guess it had that sort of dual impact."*
>
> *"We're finding that our waitlists are growing, the amount of time people are waiting for services is growing."*
>
> *"The community system cannot continue to sustain the support and respond to meet these growing needs with the current funding model."*

Recommendations

Community mental health organizations play a critical role in delivering essential mental health and addiction services and supports to Canadians. And yet, we have reached a point where these organizations and their workforce are running on empty. It is time to better fund, support and integrate our services within the healthcare system so Canadians can get the mental health care and supports they need, whomever they are and wherever they live. Their health and well-being are at stake.

Below are our recommendations emerging from the research:

Recommendation 1: Increase funding for and strengthen capacity of core Community Mental Health and Addictions services and supports

Establish long-term and stable federal funding for the community mental health sector to provide key services and supports, and strengthen accountability for the integration of these services into our healthcare system planning and delivery. These key programs, services and supports include: patient navigation, peer support, recovery coaches and supports, 24/7 distress centres with handoffs to community programs, mobile crisis teams, suicide prevention programs, youth mental health outreach programs, campus mental health programs, self-guided mental health skills building (like BounceBack), Assertive Community Treatment (ACT) teams, workplace mental health programs, mental health first aid, mental health supports for caregivers, social and emotional learning programs in schools, housing and employment supports, among others.

Recommendation 2: Increase support for mental health promotion and mental illness and addiction prevention programs and strategies

Increase the capacity for community mental health organizations to provide mental health promotion and mental illness prevention programs and services to reduce pressures on the acute-care system and ensure that all Canadians' mental health is supported during and after COVID-19.

Recommendation 3: Publicly fund community-based counseling and psychotherapy

Allocate public funding for community-based counseling and psychological therapies, including mental health and addiction counselors, structured intervention programs (like Cognitive Behavioural Therapy and Dialectical Behavioural Therapy), ACT, crisis counseling, psychiatry services, early psychosis intervention programs and group counseling, among others.

Recommendation 4: Prioritize investment in housing, income supports and food security

Greater federal leadership is needed, in collaboration with provinces, territories and municipalities, to ensure all Canadians, including people living with a mental illness or substance-use problem, have access to income supports and safe, affordable housing.

Recognition

CMHA National would like to dedicate this research to the community mental health care providers and advocates who have continued to work tirelessly, before and during the pandemic, to provide mental health care and support to people across the country. We thank you for your unwavering efforts to provide your clients and communities with the mental health care and service they have needed throughout the pandemic. Thank you, and let's continue our work towards building a fully integrated mental health system, where mental health is a universal human right.

Acknowledgements

The Canadian Mental Health Association, National is grateful to CMHA representatives across our wide federation who enthusiastically responded to our call to be interviewed for this research. Thank you for your time and generosity in sharing your perspectives, your work and your experiences of navigating the difficult waters of COVID-19. The research was made possible by generous support from Co-operators.

Introduction

"I think the mental health crisis is just starting as far as the pandemic goes." - Participant 5, CMHA Edmonton Region

COVID-19 has had an unprecedented impact on the physical and mental health of Canadians. Illness, the loss of loved ones, job losses, physical distancing, stay-at-home public health orders, lockdowns, and school and daycare closures have produced grief, trauma, stress, loneliness and hardship for many. The virus has changed the way we work, our everyday rhythms of life, and the way we connect with and relate to one another.

Over the two years, the Canadian Mental Health Association (CMHA) in partnership with UBC researchers has been polling Canadians to learn about their mental health and well-being during the pandemic. Canadians have been telling us how mental health has deteriorated over the course of the pandemic. Since the beginning of the pandemic, on average, 37% of Canadians described their mental health as being worse compared to before the pandemic. Nearly half (46%) of Canadians report being stressed or worried about coping with the prolonged uncertainty due to the pandemic, and 64% of Canadians are stressed or worried about the emergence of new variants. Our research[2] has consistently shown that Canadians who were vulnerable and marginalized before COVID-19 have been disproportionately impacted during the pandemic:[3]

- People **already struggling with their mental health** were more than twice as likely to say it had declined.
- **Canadians with low incomes** were twice as likely to have trouble coping.
- **Indigenous people** have reported greater mental health impacts than the general public, with Indigenous women experiencing heightened levels of moderate to severe anxiety.[4]

These findings may be just the tip of the iceberg. As we navigate and learn more about this ever-evolving virus, the return to "normal" that many of us long for seems further out of reach. The virus may become "endemic" in our lives, much like the common cold or flu.[5] The lingering physical symptoms of "long COVID" are often accompanied by mental health problems, like depression, anxiety and post-

traumatic stress,[6] and those managing and recovering from the grief, trauma and stresses of the pandemic will require mental health supports.

Disasters – such as environmental catastrophe, war and economic recession – have shown that human beings are remarkably resilient in coping with and recovering from psychological stress. However, disasters have also produced higher rates of suicide and mental health and substance use problems, with symptoms of illness sometimes lasting for years.[7] This has generated warnings about COVID-19 and an impending "tsunami" of mental health problems.[8]

And yet, while the pandemic has highlighted the critical importance of mental health programs and services, the cracks in our mental health system have also become more visible. As more Canadians have tried to access mental health services during the pandemic, they have faced many problems: waitlists, high cost of services and the challenges of navigating a complicated, uncoordinated patchwork of services. In March 2020, the Government of Canada declared mental health services to remain open during pandemic lockdown measures because they were deemed "essential."[9] But, the inaccessibility of mental healthcare calls us to question if it is truly an "essential" part of our healthcare system.

According to the Canada Health Act, the legislation that sets the standards for universal healthcare in Canada, all provinces and territories must insure "medically necessary" services delivered by physicians and in hospitals at no cost. For the most part, this excludes community mental health services and also privately delivered mental healthcare, which are beyond the reach of many Canadians due to cost, geographical location and other barriers.

This paper presents recommendations to the Government of Canada for recovering from the pandemic. It also recommends better supporting and integrating community mental health into our healthcare system and increasing investments in the social determinants of health, such as housing, food and income security. It recommends areas where federal investments, greater leadership and more collaboration with other levels of government can strengthen our healthcare system as we navigate through and recover from COVID-19. The recommendations are based on interviews conducted with staff representing 18 different CMHA branches, regions and divisions across 10 provinces and one territory in Canada. The representatives included frontline service providers, program directors, policy experts and executives.

We learned from this research that the pandemic has taken a significant toll on the mental health of Canadians and has, in many cases, strained the capacity of the community mental health sector, including its workforce. Our communities have not only grappled with the mental health impacts of the COVID-19 pandemic but also with what is referred to as a 'syndemic,' when multiple and intersecting issues occur at the same time.[10] Together, the COVID-19 pandemic, opioid poisoning, racial justice movement and climate crisis have:

- Accelerated the number of opioid toxicity incidents and deaths after numbers were decreasing before the pandemic;
- Increased the number of people who are homeless, unemployed and have housing and food insecurities, and created greater demand for outreach services, housing, and income supports;
- Worsened the mental health of people who were already vulnerable before the pandemic, including people with pre-existing and complex mental illnesses and substance use problems;
- Interrupted the usual social support networks that people rely on for their mental health and well-being – including family, friends, teachers, workplaces and community groups and programs.
- Increased the demand for mental health services (such as crisis services, counseling and outreach) and mental health promotion;
- Disproportionately impacted youth, people with pre-existing and complex mental health needs, Indigenous peoples, Black and other racialized peoples, newcomers and refugees;
- Increased the strain on the workforce that provides mental health and substance use services.

For these reasons, we have developed the following recommendations:

Recommendation 1: Increase funding for and strengthen capacity of core Community Mental Health and Addictions services and supports

Establish long-term and stable federal funding for the community mental health sector to provide key services and supports, and strengthen accountability for the integration of these services into our health care system planning and delivery. These key programs, services and supports include: patient navigation, peer support, recovery coaches and supports, 24/7 distress centres with handoffs to community programs, mobile crisis teams, suicide prevention programs, youth mental health outreach programs, campus mental health programs, self-guided mental health skills building (like BounceBack), Assertive Community Treatment (ACT) teams, workplace mental health programs, mental health first aid, mental health supports for caregivers, social and emotional learning programs in schools, housing and employment supports, among others.

Recommendation 2: Increase support for mental health promotion and mental illness and addictions prevention programs and strategies

Increase the capacity for community mental health organizations to provide mental health promotion and mental illness prevention programs and services to reduce pressures on the acute-care system and ensure that all Canadians' mental health is supported during and after COVID-19.

Recommendation 3: Publicly fund community-based counseling and psychotherapy

Allocate public funding for community-based counseling and psychological therapies, including: mental health and addictions counselors, structured intervention programs (like Cognitive Behavioural Therapy and Dialectical Behavioural Therapy), ACT, crisis counseling, psychiatry services, early psychosis intervention programs and group counseling, among others.

Recommendation 4: Prioritize investment in housing, income supports and food security

Greater federal leadership is needed, in collaboration with provinces, territories and municipalities, to ensure all Canadians, including people living with a mental illness or substance-use problem, have access to income supports and safe and affordable housing.

Based on the perspectives of those on the frontlines of the COVID-19 pandemic, this paper makes an informed and powerful case that now is the time to invest in mental health. If we don't build up our critical mental health infrastructure, the health and well-being of Canadians may continue to deteriorate. With the right investments and strong collaboration across governments, there is still time to avoid a tsunami.

Methodology

The recommendations presented in this paper were distilled from key informant interviews with frontline service providers, program managers and directors, policy specialists, and executives in CMHA branches, regions and divisions across Canada. Participants were recruited through an email invitation to provincial and territorial division leaders across the CMHA federation. Snowball sampling (through word of mouth and referrals) was also used, as well as targeted outreach. To ensure regional representation, at least one key informant was selected from every province and the Yukon, and wherever possible, both urban and rural areas were represented. A total of 21 participants were interviewed, representing 18 individual CMHA branches and/or divisions. The interviews were conducted and recorded on Microsoft Teams either in one-on-one sessions or in pairs if requested by the participants.

Electronic copies of the interview guide and informed consent were shared with participants in advance. Participants had the option to identify by name and job title or to remain anonymous with only their CMHA branch, region, or division named in the final report.

The interviews were transcribed and coded into themes/sub-themes. Participants had the opportunity to review the comments that were attributed to them.

This research – including project design, data collection, coding and analysis – and the writing of this paper were conducted by Dr. Leyna Lowe, National Research and Policy Analyst, CMHA National. The research and recommendations presented in this report were reviewed by CMHA's Public Policy Working Group, which is comprised of policy experts representing CMHA local branches and regions, and provincial/territorial divisions from across Canada, and in consultation with CMHA's National Council of Persons with Lived Experience, our Board Public Policy Reference Group and our National Board of Directors.

CMHA: Who we are

The Canadian Mental Health Association (CMHA) is the most extensive and established community mental health organization in Canada. Founded in 1918, CMHA is one of the longest-serving not-for-profit organizations in the country. We have a national office based out of Toronto, Ontario, 11 provincial/territorial divisions and 74 local branches or regions operating at the local level. Together, the CMHA federation has over 5000 staff and 11,000 volunteers and members working out of 330 locations.

CMHAs across Canada are very diverse in size, scope, and program/service offerings. Among the branches, regions and divisions in this research, the smallest office employed seven staff members and the largest, almost 500 staff.[11] Some branches and regions serve a relatively small catchment area, either urban, rural or both, while others reach a much larger geographic region and offer programs and services to a major urban centre and outlying communities. CMHA divisions offer programs and services either throughout their entire province or territory, or more locally.

Because most CMHAs at the branch/region level operate in a hyperlocal, grassroots manner, the programs they offer vary greatly depending on the needs of the community and the funding they receive. While some offer mental health promotion programs almost exclusively – such as school-based programming, drop-in centres, and workplace mental health training – others receive government funding to offer clinical services and direct services, such as counseling, peer support, intensive case management, crisis response, transitional and supportive housing, and outpatient or residential treatment programs for people in recovery from substance use.

Across all CMHAs, we believe in the philosophy of care before crisis – that there is so much more that can be done in communities to promote mental health, prevent mental illness and intervene early. Canada has typically invested in a "sickness care" system, with acute services and beds to care for people who are ill or in crisis. Acute care is essential, but so much more can be done and done earlier. CMHA provides the kinds of mental health services and supports that aren't always available in the public healthcare system. These community programs, services, resources and supports help people

recover from mental illness, help prevent mental health problems in the first place, and promote positive mental health in schools, on campuses, in workplaces and in the community at large. These important services also take the pressure off the acute-care system by preventing mental health problems or addressing them early.

At the national level, CMHA works on behalf of its branches, regions and divisions to advocate for mental health system change; educate people about mental illness and about mental health and how to take care of it; and shift societal beliefs and behaviours to create a climate of understanding and acceptance.

At the provincial/territorial and local levels, many CMHAs also do policy work and advocate with their governments for mental health systems change. Some CMHAs conduct primary research to support their programs, services and advocacy efforts.

We refer to the programs, services and supports that we provide today as "community mental health." The notion of "community mental health" is rooted in history. Asylums, the precursor to today's mental health system, were first imagined to be therapeutic refuges – or communities – for people with mental illnesses although many were spaces of segregation, neglect and human rights abuses. Growing critiques of the conditions of the asylums in the 20th century, paired with the availability of new medications and treatments for mental illness, precipitated a period known as "deinstitutionalization." In the 1950s and 60s, asylums were closed in favour of providing treatment for people with mental illnesses in hospitals and in the community at large.[12] CMHA's founder, Dr. Clarence Hincks, was a social reformer who played a pivotal role in deinstitutionalizing mental health services into community settings in Canada. In 1918, he had founded CMHA, first known as the Canadian National Committee for Mental Hygiene (CNCMH), to advance the "improvement of facilities for the diagnosis and treatment of existing cases of mental disability and to a programme of prevention."[13] It should be noted, however, that despite the intentions to improve patient treatment, Dr. Hincks and some CNCMH policies and practices also supported human rights violations, which undermined racial and ethnic equality, bodily autonomy, and self-determination.

Chronic underfunding is a longstanding problem in the community mental health sector, which is largely comprised of not-for-profit, charitable organizations and agencies. Even though community mental health providers offer a wide range of mental health and substance use services and supports that are essential to maintaining the health and well-being of Canadians, for the most part, community mental health programs and services are not part of Medicare, Canada's publicly funded healthcare system.

How community mental health care is delivered

In Canada, responsibilities for Medicare are shared between the federal government and the provinces/territories. At the federal level, the Canada Health Act sets the standards and rules for our publicly funded healthcare system. Provinces and territories receive transfer payments to manage, organize and deliver healthcare through their individual insurance plans, according to the standards.[14] The Canada Health Act specifies that the provinces and territories must, at minimum, provide public insurance for "medically necessary" services delivered by physicians and in hospitals. Provinces and territories can choose to provide additional insurable health services beyond what is specified in the Canada Health Act.[15] Under Medicare, most mental health services are only insurable if they are delivered by physicians, in hospitals, or by family health teams (which are multidisciplinary teams of healthcare professionals who work within a physician practice) and thus fall outside what is considered 'medically necessary' services under the Canada Health Act. The mental health services delivered in the community by community agencies and organizations are therefore not formally part of Medicare; however, provinces and territories dedicate a percentage of their healthcare budgets – typically around 5-6% of overall healthcare spending – to mental health and addictions, a portion of which goes to community mental health organizations.[16]

Although provinces and territories are largely responsible for the administration and delivery of healthcare in Canada, the system of federal cost-sharing through transfer payments recognizes the important role of the federal government in ensuring free, public and universal healthcare across Canada. However, the exclusion from the Canada Mental Health Act of most community mental health programs, services and supports – considered discriminatory even in 1957 when Medicare was first being established[17] – has placed the lion's share of responsibility for funding, governance, and policy development in mental healthcare on the shoulders of provinces and territories.

How community mental health is funded

Many community mental health programs and services are funded, often insufficiently, through a patchwork of systems within provinces and territories. A significant source of funding for CMHA branches, regions and divisions comes through contracts held with their provincial or territorial Health Ministry or Regional Health Authority.[18] CMHAs may also rely on single or multi-year grants from different sources, contributions from charitable organizations like United Way, individual and private sector donations and fundraising events, as well as income from landholdings, other investments, and bequests. Some CMHAs access federal grant money through national employment and housing programs such as Reaching Home.

CMHA services are offered free of charge, with a few exceptions.[19] Other community-based mental health services – that is, those not provided in hospitals, by physicians or in family health teams –

include private practice psychotherapy, counseling and addictions counseling. They are often paid for out of pocket by individuals using these services or through their private insurance plans.[20]

As individuals wait for extended periods, worsening symptoms and increasing urgency only add further strain to already overstretched and limited publicly funded mental health services.

Some long-term federal funding has been funneled to the provinces and territories for mental health through measures like the 2017 Shared Health Priorities, which earmarked $5 billion over 10 years to improve Canadians' access to mental health and addictions services.[21] The Shared Health Priorities are accompanied by six common indicators which provinces and territories are meant to track and report on.[22] While this funding is welcome, it is unclear how and where these funds have been disbursed.

Key findings from the research

The pandemic has had devastating impacts on the mental health, substance use and homelessness of Canadians, and highlighted pre-existing and increasing needs for services.

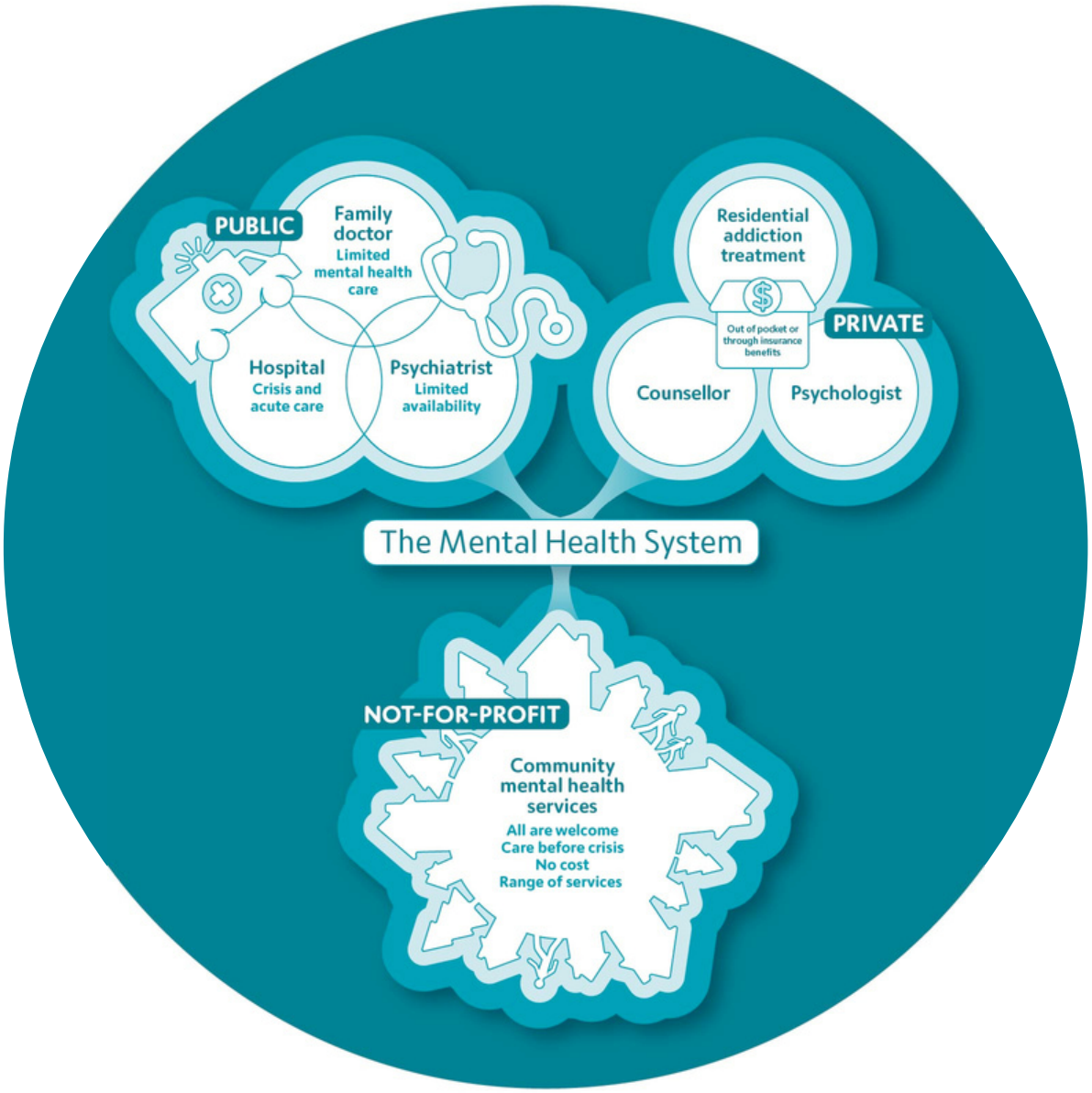
- There is a significant and growing need for mental health and addiction services available through the not-for-profit and public sectors, including ongoing in-person and virtual counseling and psychotherapy.

> *"We're finding that our waitlists are growing, the amount of time people are waiting for services is growing and the most significant area that that's happening is for counseling."*
>
> *"...actually securing a consistent, regular counselor of the kind that will actually help you, whereby you build a relationship with this person and they help you go through years of trauma, chronic illness and all, that's very, very difficult to find."*

- Virtual mental health services have improved access to mental health services for some but are a barrier for those with limited access to technology, such as seniors and people who are low-income.

> *"We also heard that from folks who ... who have access to technology, that the transition to virtual services has benefited that population of people. Conversely, on the other side of the coin, transitioning to virtual services has actually created more barriers in access to mental health and addiction services for folks who are low income, who are more marginalized, who don't have access to, you know, internet, computer, or telephone."*

The current system of care is a patchwork of programs, services and supports offered by the private, public and not-for-profit sectors.



- The mental health and addiction programs, services and supports delivered by not-for-profit organizations are crucial and need to be better integrated.

> *"I think there could be some interesting work done in [...] how we move towards a more equal relationship between clinical governmental services and community-based mental health supports, because I think so long as they remain forever separated and never connecting, other than to refer to each other, people aren't necessarily going to get the type of support that they need."*

"I'm really tired of them [mental health and physical health] being disconnected. They are connected. We are a whole system body [...] it has to be much more holistic in our approaches to link things together. So not just have mental health over here, supports and community and diabetes over there. I think there has to be much more layering going on around community supports with mental health, connected to physical health as well...not separating [them] because it keeps the stigma going."

The current funding of not-for-profit mental health and addiction services delivered by charitable organizations is inadequate and unsustainable.

- CMHAs feel that community mental health organizations are underfunded, as the provinces and territories currently dedicate only around 5-6% of overall healthcare spending to mental health and addictions, a portion of which goes to community mental health organizations.

"Because community mental health has been so underfunded, everything's kind of piecemeal...together, we get a little bit of funding here for this program, we get a little bit of funding here for this program, and then you're stuck in those kind of funding agreements [...]"

- Short-term and emergency funding should be replaced by long-term, sustainable, core funding.

"It's these little pockets of money that are never enough to actually provide the service that is expected... contracts are always late, money never shows up on time, you're reporting on it, and then you're starting the next round of proposals again because the year is up. And it's very challenging to retain the quality employees in these programs when you can never promise them stability and it's really difficult to be strategic in your work and to make plans when you're year to year just trying to say, "how can I pay myself, my admin, how do I pay the rent, and how do I pay the team members when the dollars are never enough?"

The community mental health system and its workforce are experiencing significant strain.

- Due to chronic underfunding, many mental health and addiction workers receive lower wages, higher work demands, experience compassion fatigue, are exposed to trauma and are likely to experience burnout. These effects have intensified during the pandemic.

"It was, you know, a lot of stress, a lot of people felt that because we're a mental health organization and COVID happened that this was the time to push even harder. But that came at the expense of a lot of people who were already under stress from the pandemic themselves and in their own personal lives, then feeling it as a professional in mental health that you need to now work overtime, I guess it had that sort of dual impact."

"We're finding that our waitlists are growing, the amount of time people are waiting for services is growing."

"The community system cannot continue to sustain the support and respond to meet these growing needs with the current funding model."

Recommendation 1:
Increase funding for and strengthen capacity of core Community Mental Health and Addiction services and supports

Section summary:

1.1 Scale up the infrastructure of the community mental health and addictions response through greater core, long-term and stable federal funding and the integration of mental health and addictions services into our health care system planning and delivery

The problems of patchwork funding: shifting away from contracts and grants

The need for sustainable, core and long-term funding

Strengthening community mental health and addiction infrastructure and integrating it into the Canadian health care system

1.2 Priority program areas for investment during COVID-19: What we heard

Scaled up delivery of harm-reduction and substance-use treatment services

Increased investment in peer support

Strengthened mental health education, promotion, and clinical interventions for youth and their caregivers

Increased investment in high-intensity services for people with complex care needs – Psychiatric services and ACT/case management

Supporting and sustaining the wellness of the mental health and substance use workforce
Direct investment in Indigenous-led organizations and Indigenous-led mental health programs and services

Increased support for racialized, newcomer and refugee-led mental health programs, services and organizations

1.3 Increased funding and strengthened infrastructure to support virtual mental health services

1.1 Scale up the infrastructure of the community mental health and addictions' response through greater core, long-term and stable federal funding and the integration of mental health and addiction services into our health care system planning and delivery

The patchwork of funding that sustains the community mental health sector is not adequate to build a robust, integrated, and responsive mental health system that meets the mental health needs of Canadians. In the interviews with CMHAs, a word that surfaced repeatedly was "unsustainable." Interviewees repeatedly referred to the unsustainable funding model of their organization — a mix of provincial funding, grant-based funding, corporate donations, fundraised dollars and individual donations and bequests — and to the need for funding to sustain their important work.

COVID-19 has further exposed how vulnerable a sector like community mental health can be in times of crisis when organizations lack sustainable funding. While emergency funding has acted as a stopgap during the pandemic, sustainable funding for after-care for highly vulnerable individuals will continue to pose a challenge after COVID emergency funding stops. For community mental health organizations, sustainability will mean obtaining core, long-term federal funding to ensure that their programs and services are well resourced and can be planned. However, stable funding alone will not solve the problems that currently trouble the mental health care system; rather it will also take integrating community mental health into our universal health care system and providing the resources so that community mental health organizations can strengthen their infrastructure and capacity to meet the needs of the communities they serve.

The problems of patchwork funding: shifting away from contracts and grants

Funding CMHA work involves constantly "chasing dollars" and stitching bits and pieces of funding together. While CMHA branches, regions and divisions typically receive some provincial funding, it is often contract-based, and supplemented by contracts and grants from other sources. Contract-based funding is time-limited and generates financial uncertainty. As Participant 5 (CMHA Edmonton Region) explains,

> *The other programs and services where we have received funding from the province or other contracts is for a limited time. And it's always proposal-based moving forward. So, there's always a bit of uncertainty as to what the next few years are going to be like. And we have also found that they've decreased the length of the contracts sometimes... in the past they've been up to three years long, now they're on a yearly basis.*

In addition, while programs may be funded by the province or territory, staff and administrative costs

may not be. For instance, Michael Anhorn (CEO, CMHA Toronto) notes that it is common for funders to cap program administrative costs at 10%. From his experience working in BC, he says that in provincially funded programs, "you can do direct service at one step removed from direct service as programming expense, so basically [the] frontline worker and the person who supervises them. And that's all that counts for direct programming. If there's a manager or director above that, they're not programming, they're administration." Anhorn argues that this funding model fails to "understand the realities of running a non-profit organization." When funding isn't enough to cover administrative costs and fully sustain a program, CMHAs often need to raise funds to stay afloat.

The grants-based model is also very time- and resource-intensive and prevents community organizations from planning for the future. It also makes it hard to attract and retain qualified staff. As Amanda Holloway (Executive Director, CMHA Wood Buffalo) explains,

> *It's these little pockets of money that are never enough to actually provide the service that is expected...And literally, by the time you get funding secured and you get the "yes, we're going to give you dollars," contracts are always late, money never shows up on time, you're reporting on it, and then you're starting the next round of proposals again because the year is up. And it's very challenging to retain the quality employees in these programs when you can never promise them stability and it's really difficult to be strategic in your work and to make plans when you're year to year just trying to say, "how can I pay myself, my admin, how do I pay the rent, and how do I pay the team members when the dollars are never enough?"*

Furthermore, grants, and especially federal grants tend to be very targeted in their scope and thus can be very restrictive:

> *The community system cannot continue to sustain the support and respond to meet these growing needs with the current funding model. So, while government announces, you know just 3.8 billion in investment over 10 years in partnership with the federal government, it'll help address increasing pressure, but much of the recent funding that we get it's been targeted. So, it's [for] specific initiatives. So, this will go to providing housing for this many people with this many staff. It's targeted and very specific, and it has restrictions, but our base [provincial] budgets, they just continue to be maintained over the past decade. (Chris Babcock, Director-Quality, Performance and Risk, former CMHA Elgin-Middlesex)*

Patchwork funding during COVID-19

While community mental health organizations struggle for funding even in the best economic times, COVID-19 exposed just how vulnerable these organizations are without adequate and sustainable funding. With the onset of COVID-19, mental health providers like CMHA were considered essential services and had new costs to bear for protective personal equipment (PPE), cleaning/disinfecting,

safety devices such as plexiglass barriers to deliver their services in person, as well as technological upgrades to provide virtual services. In Ontario, for instance, while there was a provincial strategy around PPE for hospitals and long-term care, the mental health sector was not included and so organizations like CMHA Peel Dufferin struggled to source and pay for their own PPE. CMHA Toronto had to find a way to cover the increase in expenses to pay for PPE during the first year of the pandemic. The branch was ultimately able to source one-time funding from the Ontario government. In addition, many CMHAs suffered revenue losses during the pandemic due to canceled in-person fundraising events. Fundraising is a critical source of revenue for many branches, regions and divisions. As Participant 2 (CMHA New Brunswick) explains,

> *We rely a lot on funding and our fundraising in order to keep our organization intact, and with this pandemic, we weren't able to do any fundraising because everything was done virtually. So, I'm going to say that has been the biggest challenge that we've ever faced just because, we used to do a lot of fundraising [...] And last year, all of our events that were upcoming had to be canceled.*

A strong reliance on fundraising also makes non-profit community mental health organizations vulnerable in times of economic downturn. CMHA Wood Buffalo in Alberta experienced a significant decrease in donations due to the economic downturn in the oil and gas industry. When not-for-profits are forced to rely on fundraising and corporate donations to support their operations, it impacts their ability to serve the community:

> *Our United Way campaign has seen a drastic drop over the years [...] They just didn't have the dollars to be able to support new initiatives or new agencies. And so, the downturn in the economy has had incredible impacts across the entire region [...] at the individual level but also at an agency level and how we're able to provide service in our community. (Amanda Holloway, Executive Director, CMHA Wood Buffalo)*

Despite the challenges associated with the pandemic and the loss of fundraising revenue, many CMHA branches, regions and divisions also benefited from a funding boost from government emergency support funding. CMHA Kelowna, for instance, had planned growth in its housing program during the pandemic, but also received additional funds through the federal Reaching Home program, allowing the branch to expand outreach services for people experiencing homelessness. Many branches and regions used emergency provincial funding for phones, tablets and data plans for their clients who otherwise would not have been able to access virtual services. Others received federal funding for their crisis support lines, and in BC, for example, mental health and addiction treatment organizations could apply for provincial grants of up to $250,000 to enhance their COVID-19 response. Some CMHAs received funding for staff wages, that, as Participant 6 (CMHA PEI) says: "made it so that we'll be able to build up some more sustainability within these programs."

In some cases, reporting requirements created administrative problems. Counting on emergency funding from governments cannot become the new norm. Community mental health organizations require more sustained, long-term investments in their programs and services to truly scale up access to care.

> *We really need sustainable funding [...] I don't want to become a pandemic-serving agency. I don't want to become a fire-serving agency. I want to continue to be a mental health serving agency and to be able to level up to the needs in my community if things happen, but I shouldn't have to be having to sustain myself off emergency dollars. (Amanda Holloway, Executive Director, CMHA Wood Buffalo)*

The need for sustainable, core and long-term funding

Many of the problems of our health care system — waitlists, reliance on emergency and crisis services, high costs of care in public spending — are a function of the underfunding of mental healthcare, the systemic discrimination towards mental health services, and lack of integration of community mental health programs and services into our universal healthcare system. CMHAs indicate that they need sustained funding to meet the needs of the communities they serve, particularly as they navigate the pandemic and the greater demands for mental health and addiction supports. Core, long-term funding — whether provided by provincial or federal governments — is needed to do this work effectively:

> *I think we need an ongoing and sustained investment in community mental health. You know, the reality is that COVID has shown that when there's a need, that a response can happen, and while an investment needs to be broad based, there should be a focus, again, on prevention, and early intervention. Those always get under-resourced, and those are the things that we always seem to be chasing dollars for, that if we have sustainable and ongoing, long-term, and by long term, this has got to live past the term of any one government. Like, we're talking at least a decade, because normally what you see is a short-term investment, and then it gets pulled back. And then we end up facing, you know, those challenges that that come up subsequent to it. So, for me, it's like it's a long-term investment in community mental health, with equitable distribution of resources across the spectrum of need. (Mike Gawliuk, Director of Service Delivery and Innovation, CMHA Kelowna)*

There are several solutions. One is an increase in the base funding from the province or territory. CMHA Ontario, for instance, has been advocating for, at minimum, a 3% base budget increase for their branches to support operating costs and improve staff compensation.[23] Another solution would be the creation of a dedicated funding stream for mental health, allocating a percentage of healthcare funding within a province or territory to these services, through a funding formula. There is a greater need for federal leadership in mental health to invest in areas where provinces have not provided adequate funding, such as mental illness prevention and mental health promotion.

Sustained funding would also help community mental health organizations collect data, perform research, and evaluate their programs to develop an evidence base for their effectiveness. Government program grants often make demonstrating the evidence base a prerequisite for funding but rarely allocate funds to help develop one in the first place:

> *"What we're seeing is governments are demanding even more accountability [...] if they're demanding that accountability, they need to fund the capacity building in those agencies to be able to report that". (Participant 1, CMHA Lethbridge)*
>
> *"There are groups who are only going to fund the things that are based in deliverables, and if a non-profit doesn't have the resources to demonstrate that those deliverables are real, it gets really confusing for how you're going to continue that community-based response." (Participant 6, CMHA PEI)*

Strengthening community mental health infrastructure and integrating it into the Canadian healthcare system

Strengthening the capacity of the community mental health response is not just a matter of funding. It is also about valuing mental health services as much as physical health services and shifting how these two models of care interact with one another. Community mental health has long existed on the peripheries of our formal health care system, which is physician- and hospital-based. It is not integrated into that system. And yet, it plays a critical supporting role by preventing the need for hospital crisis services in the first place by providing mental illness prevention services and mental health promotion, both which are proven to prevent hospital admissions.

Developing an integrated healthcare system that embeds mental health services requires that we value mental health care as critical to health. Currently, mental health is separated from physical health and is undervalued:

> *I'm really tired of them [mental health and physical health] being disconnected. They are connected. We are a whole system body [...] it has to be much more holistic in our approaches to link things together. So not just have mental health over here, supports and community and diabetes over there. I think there has to be much more layering going on around community supports with mental health, connected to physical health as well...not separating [them] because it keeps the stigma going. (Laurel Taylor, Provincial Senior Lead-Project H.O.P.E., CMHA Nova Scotia)*

In the same way that mental health is undervalued, so is the community system of care. Strengthening capacity in the mental health sector will require dismantling the artificial separation between mental health and physical healthcare to ensure better health outcomes.

We need to "move towards a more equal relationship between clinical governmental services and community-based mental health supports, because so long as they remain forever separated and never connecting other than to refer each other to each other, people aren't necessarily going to get the type of support that they need. (Participant 6, CMHA PEI)

Strengthening the capacity of the mental healthcare system therefore means valuing mental health care and including community mental health as critical infrastructure in our health care planning and service delivery:

Because community mental health has been so underfunded, everything's kind of piecemeal... together, we get a little bit of funding here for this program, we get a little bit of funding here for this program, and then you're stuck in those kind of funding agreements. What we want to do at our organization is we want to build fully comprehensive, multidisciplinary teams that work within a geography. They work directly with the primary care providers in that community. We need to have psychiatry attached to those teams. Right now, all of our psychiatry sits at the hospital, which, you know, you can't access, the staff don't know who the psychiatrists are, there likely isn't enough. So, I think there's also a piece of work that we have to do around reimagining what we have. (Lisa Ali, Senior Director, Clinical Strategy and Services, CMHA Peel Dufferin)

To be efficient and effective, mental health services need to be fully integrated into primary care and funded appropriately. And the community mental health sector needs to be engaged as partners and experts in their own right. This means moving away from a funding model based on grant proposals and contracts.

Work with us as partners that are working towards common goals so that we can develop the relationships to say this is what's working, this is what we proposed, it's what we thought would work [...] We are helping them achieve outcomes that they need and that I would even venture as far to say they can't achieve on their own. [...] So there needs to be a mutual relationship or relationship that we're partners in this, not just grant receivers. (Michael Anhorn, CEO, CMHA Toronto)

Strengthening capacity and sustainability in the healthcare system will require listening to experts in community mental health about local needs.

1.2 Priority program areas for investment during COVID-19: What we heard

While many community mental health program and service areas are underfunded due to the patchwork funding model, there is higher need in specific areas, particularly as we navigate COVID-19. The following section outlines these areas of higher need, which include harm reduction and substance use treatment services, peer support, services for youth and their caregivers, and high-intensity services for people with severe and complex mental illness, including Assertive Community Treatment (ACT), case management and psychiatric services.

Scaled up delivery of harm reduction and substance use treatment services

Substance use treatment and harm reduction are two priority areas for government investment and policy action. More people are using substances to cope with stress, loneliness and grief caused by the pandemic, and opioid-related toxicities and deaths have increased due to greater social isolation and the toxicity of the street drug supply.[24] Even before the pandemic, many communities, particularly those that are rural and remote, lacked addiction treatment centres or supports, a critical gap in the delivery of mental health services.

More supports are needed as we move through and recover from the pandemic. As Laurel Taylor (Provincial Senior Lead-Project H.O.P.E., CMHA Nova Scotia) says: "we know [that] there's issues that are going to continue on after COVID and I think that's one of the areas that we need to be prepared — to have more supports for individuals around substance use."

Social isolation, disruptions in the delivery of harm reduction services, and the increasingly toxic supply of street drugs have put people at greater risk of overdose and death.[25] This is an area "where there could have been better investment and quicker movement [federally and provincially] was in the whole area of problematic substance use and access to alternatives to street drugs [...] because the other thing that the whole social isolation thing did is result in more people were using substances by themselves." (Mike Gawliuk, Director of Service Delivery and Innovation, CMHA Kelowna)

Higher rates of opioid and alcohol toxicity have contributed to service disruptions since the onset of COVID-19:

> *But when we got shut out of some of the places where we [operate], and we started doing more virtual, people didn't know where to go for addiction medicine so you actually, and our hospital partners will tell you this, they saw a spike of alcohol and opioid overdose presenting at the emergency department. And it was because the services weren't where people expected them to be. And so they went to the next best thing, which was going to the hospital. (Lisa Ali, Senior Director, Clinical Strategy and Services, CMHA Peel Dufferin)*

The policy response to the opioid crisis has been inadequate at all levels. In some cases, provincial governments have scaled back on supervised consumption sites and harm reduction programs or have not sufficiently invested in these services in the first place. Many smaller communities do not have a supervised consumption site, and while others have some harm reduction programs in place, such as needle and Naloxone kit distribution, they tend to be small and underfunded, like the harm reduction program Blood Ties Four Directions in Yukon.

In addition, residential substance use treatment services are also in short supply in many communities. In Saskatchewan, often clients must pay for services offered in BC or even in the United States because the number of residential treatment spaces is so limited there. Some people with treatment needs beyond the usual 28 days will "surf" programs to extend the length of their treatment, which is disruptive to the recovery process. At CMHA Muskoka Parry Sound, Executive Director Diane Brown-Demarco says: "We're doing not a bad job when it comes to harm reduction, when it comes to getting people access to addiction medicine, but we don't have residential treatment beds here. So, if someone needs to have that service they need to, we need to help them go to Orillia or North Bay or Sudbury or somewhere else in the province to do it." Traveling outside one's community to access services poses problems because people are away from their support systems. Transportation can also be a barrier, as Participant 3, CMHA Northern BC, says: "The Greyhound services are cut down and people aren't able to access public transportation. So, unless you had somebody that could drive you to the treatment centre, it is a challenge to get people to services."

Increased investment in Peer support

What is Peer Support?

Peer support, broadly defined, is "emotional and practical support between two people who share a common experience, such as a mental health challenge or illness. A Peer Supporter has lived through that similar experience and is trained to support others." [26]

Peer supporters can be embedded in a wide range of programs, services and therapeutic environments, including drop-in programs, crisis services, Assertive Community Teams, supportive housing, crisis services and hospital emergency and inpatient units. They may offer workshops, help with teaching self-advocacy and navigating the mental health and substance use system, self-determination through non-judgmental listening, support in working through difficult feelings, help in increasing social connections, support in accessing resources related to shelter, housing, food and recreation, and support to family members, among many other things. [27]

According to CMHAs, peer support is a critical resource but is under-recognized in our healthcare system. As Participant 2 (CMHA New Brunswick) says: "Peers have the biggest impact on all of the clients. Just because they know what they've been through, and they've been through the system and they're really able to provide hope and care and support to the individual and that's exactly what they need." Peer support is not only meaningful for recovery, as Laurel Taylor (Provincial Senior Lead-Project H.O.P.E., CMHA Nova Scotia) says, it is also very "economical" and "best practice" in that "many people get together and help each other."

There is, however, a lack of funding for peer support. Peer supporters are critical following discharge from a hospital or a psychiatric unit, as peer supporters can follow-up and help with service navigation and other supports in the community. However, they are not often available, as Executive Director Diane Brown-Demarco notes: "We don't have peer support in our emergency departments in Muskoka or Parry Sound. We just aren't funded for it. And it could make such a difference with working alongside our crisis team."

Although some CMHAs offer peer support in their branch, region or division, there is a strong need to scale up their capacity and to embed more peer supporters in additional programs and services within their community. An important barrier is the underappreciation of peer support outside of the community mental health sector.

> *Peer support, in general, I think is an area that needs to be augmented in terms of its use. I think it can do a lot more than we are currently allowing it to do. [...] investment in that front would be really helpful, especially around the training for professionals of how peer support is relevant to their work. So, we here in PEI, that's the battle we're currently facing is how do we help clinicians, how do we help doctors and nurses and paramedics understand where peer support fits into their practice, because it's not usually part of what they do. Having them understand who they could refer to or how that might support the wellness of their clients, I think would be really helpful. (Participant 6, CMHA PEI)*

CMHA staff also identify peer support as a key program area for businesses, schools and workplaces as they begin re-opening post-COVID-19:

> *As people start getting back to their new normal, getting back to work, we're definitely going to see, I think, increased need for those kinds of peer support type of activities, Recovery Colleges.... Ninety per cent of people's lives is not in the psychiatrist's office. It's not in their physician's office. It's out in the community. So, I think ensuring that we've got those wraparound community supports for them to go to.... Everything from counseling support, to peer support, to wellness [and] recovery. (Participant 1, CMHA Lethbridge)*

Well beyond COVID-19, peer support is a valuable service to embed in many different settings, from healthcare to schools, communities and workplaces, because it promotes mental wellness and supports individuals who might be struggling. As Participant 2 (CMHA New Brunswick) says: "There should be peer support everywhere. Every department, psychiatric unit, emergency department... everyone has mental health, and you can just have something going on, you can be struggling with your physical health...that affects your mental health [and] you just need that support." In order to make peer support available in these settings, these services must be valued and funded.

Strengthened mental health education, promotion, and clinical interventions for youth and their caregivers

Youth as a group — those aged 15 to 29 — have had greater mental health concerns during the pandemic and need more mental health services. They have been at heightened risk for anxiety, depression and suicidal ideation, having experienced school closures, the stresses and challenges of virtual learning, isolation and separation from peers, and stress in the family (related to job losses, economic hardship, relationship strain due to confinement), all of which are more difficult given that youth is a critical time for developing social connections and identity. As Participant 7 (ACSM Montréal) says: "Young people have been very isolated, with no school, the lockdown [...] it can be harder for them than for seniors because young people are building their identity."

> *In terms of youth programming, we know that more youth are contemplating suicide. The suicidality of youth has increased exponentially, but so has the Kids Help Phone, [it has seen] a 350% increase in calls. And so, I think what we've been able to do is also evaluate the work that we've done in reducing stigma... [and] one of those outcomes that we have in mental health promotion in schools is that increase to help seeking behaviour. (Stephen Sutherland, Promotion Director, CMHA Manitoba and Winnipeg):*

Since the onset of COVID-19, CMHA Toronto has seen a surge of nearly 300% in the number of youth 24 years and under accessing their Early Psychosis Intervention Program.

> *We need to address that increase [in youth with serious mental illness], but that means there's even more youth out there who are suffering...I think youth need to be clear focus for this [during the pandemic]. (Michael Anhorn, CEO, CMHA Toronto)*

Families and teachers are reaching out to their CMHAs for tools to support young people experiencing mental illness and mental health stressors.

The canary in the coal mine for us, in a lot of ways, were the parents and caregivers who were struggling because they were seeing that this isolation was happening for their child or their teen and so, we saw more parents coming forward saying, "what do I do?" "How do I manage this?" (Mike Gawliuk, Director of Service Delivery and Innovation, CMHA Kelowna)

CMHA New Brunswick received requests from schools on how to support students' mental health, and ACSM Montréal saw a record number of downloads of their toolkit for professionals serving youth:

We reviewed, corrected, and updated our educational activity booklet for professionals to talk to youth about mental health. And since it was published, a year and a half ago, it has been downloaded close to 1,000 times. This reflects both the need for and level of mental health services for young people, which is an area we would like to develop. The pandemic has been difficult. It has been particularly difficult for young people. We can tell in part by the number of downloads. (Participant 7, ACSM Montréal)

Even prior to the pandemic, the mental health needs of youth were not being met in their communities. At CMHA PEI, while they provide school-based mental health promotion programming, there is a gap when it comes to youth-specific intervention services. The significantly higher rate of youth suicide in Northern Saskatchewan, particularly among Indigenous youth, prompted CMHA Saskatchewan Division to offer BounceBack and Living Life to the Full for people aged 15 and up. The division also developed innovative programs that use music-based narrative therapy and mentally safe Minecraft to engage youth in conversations about mental health and wellness in ways that are accessible and fun.

As we navigate and recover from the pandemic, it will be critical to support children's and youth mental health; this means supporting community mental health organizations to continue to innovate and to reach youth in their communities.

Increased investment in high-intensity services for people with complex care needs — Psychiatric services and ACT/case management

This study revealed that people with pre-existing, high-acuity and complex mental illnesses have been being particularly vulnerable during the pandemic and in need of improved access to services. Prior to COVID-19, there were waitlists and gaps in the coordination of services, but the pandemic put greater pressures on services as the demand grew; at the same time, access to programs was complicated for this group because they did not always have the technologies required for virtual services. Critical investment is needed for this group for housing and outreach, addiction medicine, psychiatric services, Assertive Community Treatment (ACT) and case management. Since harm reduction and treatment for problematic substance use have been addressed earlier in the paper, and Recommendation 4 focuses on improving housing and outreach for homeless populations, this section will discuss ACT and case management, psychiatric services and models of care and collaboration within the formal healthcare system.

Psychiatric services: healthcare services delivered by a medical doctor or a psychiatrist, focused on the "diagnosis, treatment and prevention of mental, emotional and behavioral disorders." [28]

Assertive Community Treatment (ACT): "provides intensive support services for individuals with serious mental illness who have very complex needs, and who find it difficult to engage with other mental health services." [29]

Case management: provides support to individuals living with severe and persistent mental illnesses to be independent, improve quality of life and help the person on their path to personal recovery. Case managers provide a range of ongoing services, as needed, including: intensive long-term support for individuals who are homeless or at risk of homelessness, people involved with the criminal justice system, support with day-to-day activities including banking, medical appointments, and budgeting. [30]

The significant underfunding of vital mental health and addiction services for those with complex and acute mental health needs pre-dates the pandemic. Programs for people with complex mental health needs tend to be underfunded, as Michael Anhorn (CEO, CMHA Toronto) says: "We have had an increase in demand for almost all of our programming for people with severe mental illness... But there's no one program that fixes that. Like, that's a suite of programs, it's a decision I think the provinces need to make to adequately fund mental health or response to mental illness."

CMHA Muskoka-Parry Sound has long waitlists for Assertive Community Treatment (ACT) and case management, due to underfunding. Their waitlist for case management is now from 30 to 60 days. As Executive Director Diane Brown-Demarco says: "We haven't had investment in ACT probably in 12 to 15 years. So, we're still doing the same old with shrinking resources because you can't find the same amount of resources as you did 15 years ago. [It's] getting to the point that now we have waitlists. Yeah, and that's sad because those people need a lot of support."

With the onset of COVID-19, CMHAs saw an increase in the number of people with complex mental health problems accessing their services:

[The] people who are coming, you know, calling and asking for services or going to the emergency department because we do the crisis support there as well, their issues are more complex than in previous years [...] staff are finding the people coming for help need more help. [...] whether it's grief, whether it's depression, anxiety and although all of those things that people come to us, often around anxiety... the symptoms being presented are worse, seem to be worse than they were in previous years. So, it takes more effort or more sessions or more contacts and more support. (Diane Brown-Demarco, Executive Director, CMHA Muskoka-Parry Sound)

However, when programs and services became virtual due to the pandemic, those who faced the biggest barriers to access were the most vulnerable clients, namely those who have a severe mental illness and are low income.

> *A lot of folks don't have the means to get access to the virtual space that's actually confidential. I mean you can go to the library, maybe, and be on online, but can you talk to your... psychiatrists? [...] And in the north, we also have a lot of spotty internet, a lot of folks with serious and complex mental health issues would be struggling to afford that technology, both the hardware and having internet access. (Rebecca Rackow, Director of Advocacy, Research, and Public Policy Development, CMHA Saskatchewan)*

CMHAs providing higher intensity and more urgent care services report that, given these technological obstacles, these services continued to be offered in person for the most part, including Assertive Community Treatment (ACT), case management, outreach, justice programs, and mobile crisis response.

There are also concerns about how Medicare-funded services provided by physicians and psychiatrists are organized and delivered to those with complex mental health concerns. A significant gap exists in psychiatric care, particularly in rural and northern communities. Some communities do not have a single practicing psychiatrist. According to Tiffanie Tasane (Executive Director, CMHA Yukon), "it is a challenge in the Yukon. We have a limited number of psychiatrists [...] the bureaucracy and red tape in order to access that is how you have to go through it, you have to have a family doctor. Well, many of the population don't have a family doctor." Saskatchewan, too, faces a critical shortage of psychiatric care:

> *We have only about a third of the number of inpatient beds that we had 20 years ago. They have been decimated. Every single budget that came out, they would probably announce we are closing 12 more inpatient beds in psychiatry, because they're not needed. Well, you know why they weren't needed is because there were no psychiatrists around to make referrals. (Dave Nelson, Senior Consultant, CMHA Saskatchewan)*

Without adequate access to psychiatric care, those requiring outpatient follow-up after discharge from the hospital often do not receive it.

> *We don't have a lot of psychiatrists in our town. Our psychiatrists are backlogged [...]. So, this, this is a hot-button topic for us. How do we support individuals outside of the hospital, who need a higher level of intervention, but a three-day admission on our inpatient unit and then sending them back into the community, it's just not enough? (Dave Nelson, Senior Consultant, CMHA Saskatchewan)*

Recent studies report that psychiatrists in Canada tend to be located in urban/metropolitan areas and are often unavailable in rural and remote communities.[31] Even in a province such as Ontario where there is a high number of practicing psychiatrists, equity of access is a significant problem: people with the highest income and milder symptoms of mental illness have better access to psychiatrists than those with lower-income people who have more complex mental illnesses.[32] This underlines the need for better geographic distribution of psychiatric services (both inpatient and outpatient) across Canadian communities, and also a reorganization to ensure that psychiatric services are being accessed by the populations who need them most.

Primary care only delivered by family doctors may also be an inadequate model of care for people with complex mental health needs. The care provided by family doctors is based on fee-for-service billing for every patient they see, which may affect how long they spend with each patient.

> *Most primary care providers won't take on people with complex mental health [needs] because you can't do it in a 10-minute session, and any longer than 10 minutes, you can't make a living off your practice, right? So, we [at CMHA Toronto] were like, well, let's get nurses on salary and nurse practitioners on salary, so that they don't have to stick to a 10-minute appointment and they will treat our clients because they're employed by us. And so that's worked really well for us. (Michael Anhorn, CEO, CMHA Toronto)*

An innovative model of clinical practice in Vancouver has demonstrated effectiveness in treating people with complex mental health needs. Physicians work at the clinic three days a week and are salaried — rather than paid by visit or procedure — which eliminates time constraints. The shortest appointment is 30 minutes. The clinic has also integrated peer navigators (individuals with lived experience who help connect patients to services and supports in the community).

The divide between community mental health and the formal healthcare system must be bridged to better serve people with complex mental health needs. For instance, CMHA PEI provides services that focus on rehabilitation and wellness, like peer support, and clients also interact with clinical services delivered by primary care physicians, psychiatrists, and in hospitals. This "circle of care" model allows information sharing and collaboration among the client, the clinical providers and therapeutic service providers, improving outcomes for clients and empowering community mental health providers to do their work more effectively:

> *I think there could be some interesting work done in terms of how we implement that kind of programming, how we move towards a more equal relationship between clinical governmental services and community-based mental health supports, because I think so long as they remain forever separated and never connecting, other than to refer to each other, people aren't necessarily going to get the type of support that they need. (Participant 6, CMHA PEI)*

As noted in Recommendation 1.1., in order to meet complex mental health needs, core, stable and sustainable funding is required to fund the critical mental health services offered by community mental health organizations. However, funding alone is not the answer; we need to reimagine how community mental health and other healthcare providers collaborate with one another so that we can both improve access to psychiatric services for people with complex needs and fix shortcomings in the formal health care system.

Supporting and sustaining the wellness of the mental health and substance use workforce

The mental health and substance use workforce is a group in need of greater support. These workers are exposed to higher levels of trauma, are more likely to experience burnout and, owing to underfunding, may receive lower wages, higher work demands and experience significant compassion fatigue. This was the case even before the pandemic. Mike Gawliuk, Director of Service Delivery and Innovation from CMHA Kelowna says: "When I look at our staff, and I look at the access to supports for our staff, our staff that are exposed to trauma day in and day out, working with people who are having drug overdoses [...] And so as a result, those individuals aren't getting those services."

When mental health resources are inadequate in a community, the staff must work harder to fill service gaps, often at the expense of their own well-being. In Saskatchewan, for instance, because the province does not have its own crisis line, it is peer supporters who answer distress calls, which has led to significant burnout and turnover among peer supporters:

> *We were burning through peer supporters because even though you tell them 'Turn your phone off, you're not the only person on the planet this person can talk to, you need to take some time for you, do some self-care, get some rest.' But even though you do that, they have great big hearts, great big hearts, and don't want to do that. (Rebecca Rackow, Director of Advocacy, Research, and Public Policy Development, CMHA Saskatchewan)*

The community mental health workforce tends to be compensated at a lower rate than other healthcare providers. CMHA Toronto, which employs 35 full-time nurses, had seven vacancies throughout the pandemic which could in part be attributed to the wage gap between community mental health settings and the public sector.

> *We've had just a horrific turnover in our nurses over the course of a pandemic. And when we started to dig into what's going on, what we found is that the wage disparity between what we can pay in the community, and what they get paid at public health and in the hospitals is up to 33%. And so, you know, and I don't blame anyone to go and do the same job and get paid 33% more. [...] I think non-profits tend to be better places to work, but no matter how good you are as a place to work, you can't make up a 33% wage difference. Might make up a 10% wage difference, but not a 30-some per cent difference. (Michael Anhorn, CEO, CMHA Toronto)*

Participant 6 (CMHA PEI) says: "Staff in community mental health sometimes describe their work as a labour of love. The people who have worked with our organization are here because they care, like they truly care about the work that they're doing. They're definitely not here for the pay because they could do the same job for a lot more if they went to the government."

During COVID-19 when schools and daycares were closed, the community mental health workforce faced even greater demand for services while also balancing childcare and other additional responsibilities at home. Many staff worked overtime while also providing emergency COVID-19 relief services, including at vaccine clinics, isolation hotels, and crisis supports.

> *It was, you know, a lot of stress, a lot of people felt that because we're a mental health organization and COVID happened that this was the time to push even harder. But that came at the expense of a lot of people who were already under stress from the pandemic themselves and in their own personal lives, then feeling it as a professional in mental health that you need to now work overtime, I guess it had that sort of dual impact. (Participant 4, CMHA)*

The quality of mental health services in communities is tied directly to the wellness of its workforce. With the community mental health workforce already severely overstretched, funding is needed to not only ensure the continued availability of high-quality mental health services, but also to ensure the health and wellness of those who provide these services.

Direct investment in Indigenous-led organizations and Indigenous-led mental health programs and services

Indigenous peoples, racialized communities, and newcomers and refugees face systemic discrimination and are underserved by mental health services. These communities were underserved before the pandemic and COVID-19 has heightened their vulnerability.[33] Racist events during the pandemic also highlighted the greater need for mental health supports within and for these communities.

Indigenous peoples are an important group when it comes to accessing mental health services because a legacy of colonialism and racism in Canada has created significant health disparities between Indigenous and non-Indigenous peoples. CMHAs pointed to significant concerns that Indigenous peoples face in their communities, including the high rates of suicide in some Indigenous communities in northern Manitoba, the absence of accessible mental health and addictions services for Métis in Saskatchewan, the failure of governments to ensure quality housing and clean water for First Nations in Alberta, and the high rates of opioid toxicities in Alberta.

CMHAs identify gaps in access to services for Indigenous communities and also recognize this gap in their own branch, region, or division. Much work needs to be done to improve Indigenous services, but this must be done in partnership with the communities themselves to ensure that CMHAs have the

necessary cultural knowledge and cultural competence to build long-lasting relationships of trust and respect. CMHA Manitoba and Winnipeg has been cultivating meaningful partnerships with Indigenous communities to help produce and deliver culturally relevant programs and services. Their approach has been rooted in one of "co-design;" rather than creating a program and then "inviting" Indigenous communities to take part, the notion of co-design is rooted in meaningful engagement from the onset of planning of a program, service or support to its delivery in communities. For mental health services to be equitable, accessible and culturally appropriate for Indigenous communities, mental health services must be co-designed with Indigenous-led mental health organizations and acknowledge and address the historical roots of trauma and racism that underpin many mental health issues in Indigenous communities.

Increased support for racialized, newcomer and refugee-led mental health programs, services and organizations

Black and other racialized communities

Before the pandemic, racialized communities were underserved when it comes to community mental health and addiction services. As Lisa Ali (Senior Director, Clinical Strategy and Services, CMHA Peel Dufferin) says: "Our Black residents aren't accessing services the way that other populations would be... I don't think it's necessarily the pandemic, but I think the pandemic has helped us see, you know, who are coming into our services and who are not." This can in part be attributed to the small number of racialized staff, but also to a lack of training among non-racialized staff. Similarly, at CMHA PEI:

> *Our staff are consistently asking for more training around working with diverse populations with complex needs. Really, just with every new and expanding topic as it relates to mental health, our staff are feeling as though they're ill equipped to necessarily move into those spaces. So, things around trauma, things around, I already mentioned addictions, around gender diversity or racial diversity, making sure that they have the skills and the resources to properly care for the clients and the people that they're seeing. (Participant 6, CMHA PEI)*

Long before the pandemic, the risks associated with experiencing a mental health crisis were intensified by systemic racism, including anti-Black and anti-Indigenous racism. As we have seen in recent police responses to mental health crises, systemic racism can have tragic consequences for racialized persons. Lisa Ali (Senior Director, Clinical Strategy and Services, CMHA Peel Dufferin) describes recent tragedies: "We've had Mr. Choudhry and DeAndre Campbell, who had lost their lives by interactions with the police who, you know, clearly had mental health concerns [...] this was happening alongside the pandemic, right? It was actually another pandemic in itself."

Serving Black and other racialized communities better will require a shift in the healthcare response so that the responsibility for mental health apprehensions shifts from the police to crisis workers. Ali

suggests that it is critical to shift "mental health apprehensions under the realm of the health care provider who can make the assessment and determination around hospital." Better data collection at local CMHAs would help identify gaps in services to racialized communities and help them create strategies to better reach them.

Newcomers and refugees

A lack of mental health resources for newcomers and refugees, and the lack of programs and services available in multiple languages, make it difficult for newcomers and refugees to find and navigate mental health supports. COVID-19 made these groups particularly vulnerable. A rise in racism and protectionism among some Canadians, owing to the problematic association of newcomers with virus spread, has had an impact on this community's mental health:

> *We also saw a lot more pressure on immigrant...new Canadians and immigrant groups, both because of discrimination related to the pandemic and I think just also, when people are more stressed, they're mean to each other, right? So, people that are often racialized experienced that more during the pandemic, and it impacted their mental [health]... symptoms more during the pandemic. (Michael Anhorn, CEO, CMHA Toronto)*

The greater racism and its resulting mental health impacts mean that community mental health organizations must provide more responsive and culturally appropriate programs and services.

1.3 Funding and infrastructure to support virtual mental health services

Community mental health agencies require funding and infrastructure supports to provide virtual mental health services to ensure that those in rural and remote communities, vulnerable populations or those facing other barriers can still access quality mental health services.

The future of mental health services will be a hybrid in-person/virtual model, according to many CMHA leaders and staff. The delivery of virtual mental health services during the pandemic demonstrated that not only is it possible to successfully deliver services in this way, but also that they can enhance access. However, virtual services also come with considerable challenges. Community mental health agencies will need funding to upgrade their technology infrastructure and to ensure their most vulnerable clients have access to the technology they require.

Virtual services have allowed many CMHA branches, regions and divisions to increase their efficiency and to serve a larger pool of clients/participants. This is true for both education-based mental health promotion activities and clinical services. For instance, CMHA New Brunswick began offering virtual mental health promotion presentations during the pandemic and more than doubled their reach,

surpassing a 2019 target of 85,000 to well over 200,000 in 2020. On the clinical side, CMHA Peel Dufferin completely altered its model of service provision to meet the greater levels of distress in the community resulting from COVID-19. They created a triage team that could fast-track clients to appropriate services without wait times. Because many of the branch services had become virtual, with in-person services reserved for clients with complex needs and higher acuity, CMHA Peel Dufferin was able to redeploy staff to the triage team.

> *We knew mental health [during the pandemic] was going to be an area that we were going to see an increase in. So, we developed what we call our triage team. It was a live answer from 8 in the morning till 8 at night, and you got immediate service. You got a mental health or an addiction worker when you called the organization and they could triage you. If you needed immediate services, like our crisis team, we could get you connected with that. And within 24 hours, whoever called and needed to have service, they would have a brief intervention, so one or two counseling sessions, or they would be triaged to a group. We wanted to be as responsive as possible during the pandemic. (Lisa Ali, Senior Director, Clinical Strategy and Services, CMHA Peel Dufferin)*

This model has been so successful that CMHA Peel Dufferin will continue to work this way post-pandemic.

The virtual model has made it possible for CMHAs to broaden the populations they can serve. Many communities, particularly rural, remote and Indigenous communities, lack critical mental health services forcing individuals to travel to urban centres for care. At CMHA Edmonton Region, virtual education and support programs made it possible to expand service to outlying rural communities.

Several CMHAs reported that the virtual platform improved access for those with serious mental illnesses who had the necessary technology.

> *One of the benefits of virtual services is you don't have to leave your home. So, for people who are uncomfortable leaving their home or have transportation challenges, being able to just, you know, get up and sign in or connect is really convenient…some clients who we struggled to connect to services now are really engaged." (Diane Brown-Demarco, Executive Director, CMHA Muskoka-Parry Sound)*

In addition, many CMHAs found that because it offers anonymity, the virtual format removed some of the stigma of accessing mental health services. As Participant 6 (CMHA PEI) says: "We have heard from some individuals that they feel that virtual is a safer entry point for them… there's likely some layered stigma in there, they don't have to go into our building, they don't have to be seen associating with CMHA, but they can still receive the support from CMHA."

However, virtual services were not equally accessible for all populations. At CMHA New Brunswick education sessions that were previously well-attended by vulnerable populations, tended to be attended by health professionals such as nurses once they were offered virtually. At one CMHA, educational sessions appealed to more of a middle-class and white demographic and less to lower income and more vulnerable populations:

> *We also heard that from folks who ...are, middle class, who are privileged, who have access to technology, that the transition to virtual services has benefited that population of people. Conversely, on the other side of the coin, transitioning to virtual services has actually created more barriers in access to mental health and addiction services for folks who are low income, who are more marginalized, who don't have access to, you know internet, computer, or telephone. (Participant 4, CMHA Newfoundland-Labrador)*

In addition, virtual services were also a barrier for seniors and for those who are not well versed in the use of technology:

> *I worked with quite a few people that struggled with the virtual world and even booking appointments or trying to set stuff up or explain what they needed help with through an online or phone form didn't work for them. If you're already anxious and you're having to learn something new that can, you know, complicate the situation. (Participant 3, CMHA Northern BC)*

To address barriers, many CMHA branches, regions and divisions started loan programs for technological devices and provided clients with data plans, drawing on funds they had received through government COVID-relief grants, their own reserve funds, or funds from donors or community partners. CMHA Toronto, CMHA Nova Scotia, CMHA Edmonton Region, CMHA PEI, and CMHA Muskoka-Parry Sound are only a few of the many CMHAs that created a loan program for smartphones and tablets and provided their clients with data plans. This was "life-changing" for many:

> *[A colleague in our peer support program] was able to get funding in the Cape Breton area for Internet, and devices for individuals that couldn't afford it and [it] has been life changing for those individuals. They couldn't get it on mainland Nova Scotia, but they got it for Cape Breton. So to me, we're able to get people who are say on income assistance and could not afford internet or a device in their hands for two years now for free. And so, that opens up the world of being able to talk to the counselor, if need be, or just be part of a peer support. (Laurel Taylor, Provincial Senior Lead-Project H.O.P.E., CMHA Nova Scotia)*

However, the community mental health sector will need additional funding to sustain virtual capacity.

Platforms can get expensive especially in an organization our size if you have to pay by user. ... along the same lines of virtual care... not all of [our participants] have access to technology. They can't access virtual services. They may not even have cell phones. So, again, it's funding or some support to be able to provide the participants with internet services, tablets or cellphones or something so that should maintain virtual care for a long time [...] (Chris Babcock, Director-Quality, Performance and Risk, former CMHA Elgin-Middlesex)

In addition, introducing new technology infrastructure or upgrading an outdated one can be costly. Many CMHAs reported significant difficulties in pivoting to the virtual platform at the onset of COVID-19 because their branches and regions had previously only offered programs and services in person because they lacked the technology. Accordingly, these CMHAs experienced delays of a few weeks to several months in getting their virtual offerings up and running.

CMHAs highlight that in-person services should always be on offer, noting that in-person programs and services sometimes perform better and promote social connection. They see the future of community mental health services as a hybrid virtual/in-person model of programs, services and supports. Funding to support the technology infrastructure of their organizations and for vulnerable clients is required.

Recommendation 2: Increase support for mental health promotion and mental illness and addiction prevention programs and strategies

Strengthen the capacity for community mental health organizations to deliver mental health promotion and mental illness prevention programs and services to reduce pressures on the acute care system.

Mental health promotion, mental illness prevention and early intervention programs and strategies will be key to navigating and recovering from the mental health impacts of COVID-19. As schools and workplaces reopen, young people, educators, workplaces, and communities need supports to manage heightened anxieties, stress, grief and trauma.

What is mental health promotion?

While most efforts to support mental health focus on symptoms management and/or the treatment of addiction or illness, mental health promotion takes a proactive approach, focusing on the early and continuous development of positive mental health. Mental health promotion cultivates positive mental health in individuals and communities through a combination of interventions across the life course, in communities, workplaces and schools.[34] According to the World Health Organization, mental health promotion "involves promoting the value for mental health and improving the coping capacities of individuals rather than amelioration of symptoms and deficits." [35]

Examples of mental health promotion programs include suicide prevention and awareness, drop-in programs, Recovery/Discovery Colleges/Well-being Learning Centres, BounceBack, Living Life to the Full, Social and Emotional Learning (SEL) programs for youth, workplace mental health programs and positive parenting programs and workshops. Mental health promotion also emphasizes the entire community and addresses the social determinants of health, which include factors like social inclusion, freedom from violence, housing, employment, etc.

What is mental illness prevention?

Mental illness prevention interventions are typically implemented ahead of the onset of a "clinical episode," and focus on reducing the "incidence, prevalence or seriousness of targeted mental health problems."[36] Mental health prevention strategies typically focus on "risk factors, hence need to be implemented at specific periods before the onset of the disorder in order to be maximally effective. However, once the disorder has developed, it is still possible to reduce its severity, course, duration, and associated disability by taking preventive measures throughout the course of the disorder." [37]

Given that a core philosophy of CMHA is to promote mental health and prevent illness, all of our branches, regions and divisions across Canada offer mental health promotion and mental illness prevention programming.

At CMHAs, there is considerable demand for mental health promotion and mental illness prevention programming, often exceeding what individual branches, regions or divisions can provide.

Scaling up existing mental health promotion services

Mental health promotion is critically important in preventing mental health crises and in taking the pressure off the acute-care system – a system of high-intensity services designed to serve those with complex mental illnesses and substance use problems. However, despite its known benefits, mental health promotion continues to be undervalued and underfunded. Mental health promotion strategies can help Canadians support their mental health and recover from the impacts of the pandemic, thereby allowing us to use our healthcare resources as effectively as possible.

Mental health promotion offers excellent value in sustaining community wellness. A kind of "gym for your mental health," mental health promotion aims to help people develop the skills to manage the stresses and challenges of life, preventing mental health problems in the first place. Speaking about her branch's Recovery College, Christine Stewart (Executive Director, CMHA Red Deer) explains:

> *If we can make it the social norm that people should drop into a course on a regular basis to make sure they're prioritizing their mental health and, if they had a place where they could just pop in and talk to a peer, and say, "I'm having a rough day today." They don't need counseling, they just want someone empathetic, who's not their family [...] to empathize with them and give them some concrete things that maybe they could try.*

Health promotion programs and supports play a critical role in reducing mental health crises and alleviating the pressures on the acute-care system. Mental health promotion programs, specifically, in schools and workplaces will have a great return on investment:

> *People are going to need help to rebuild their resilience and, and I think the best way to reach the most people are through school and work. And so, if you're thinking about a population-level health intervention, if we could help workplaces work with their staff to build resilience and to kind of refill those drained batteries, and how to keep them hopeful going forward and how to identify your, your suffering, right? Between work and school, we get to the vast majority of the population. (Michael Anhorn, CEO, CMHA Toronto)*

Even though there is good evidence that investment in mental health promotion reduces costs in our healthcare system, mental health promotion is not accorded the same importance as treatment-based care.

> *A very important issue is access to mental health and prevention care as well as the development of our own focus, i.e., promotion and prevention, to give them as prominent a place as treatment and healing. (Participant 7, ACSM Montréal)*

Mental health promotion has been neglected, as demonstrated by how it has been funded. At CMHA Toronto, mental health promotion programming relies on fundraised dollars and United Way funding, because provincial funding isn't adequate.

Mental illness and addiction prevention programs

While many CMHA health promotion activities have expanded, many mental illness and addiction prevention activities such as drop-ins were suspended during the pandemic due to public health measures, as were in-person peer groups, including cooking groups, gardening groups and coffee chats. At CMHA Muskoka-Parry Sound and CMHA Toronto, in-person groups were replaced with peer-based wellness checks conducted over the phone. Service disruptions particularly affected people with severe and persistent mental illnesses and seniors, as drop-ins and peer groups typically offer support and help combat isolation.

> *We provided a safe place for people to go. Somewhere where they (participants) could be referred (to other services/programs) or just even have a hot meal; it's that safe space. And that is something that was impacted [by COVID-19], definitely, especially by the women but also in the drop in. And then the other one would be wellness. So being able to go to the Y with a group of people. [...] we have a wonderful program in partnership with a library where anybody can walk up and get some information and talk to somebody live in the moment at the library about mental health and what services we have to offer. [...] that outreach, that drop-in style [program]. That was one of the hardest hit. (Chris Babcock, Director-Quality, Performance and Risk, former CMHA Elgin-Middlesex)*

With the closure of drop-in programs, significant work is needed to ensure that individuals with severe illnesses and those in recovery are equally prioritized. Whether in schools, workplaces or within communities, promoting the mental wellness of Canadians, no matter the severity of their illnesses, will be important to our collective recovery, but only if it is funded adequately.

Investing in mental health promotion and mental illness and addiction prevention is key to pandemic recovery

Investing in mental health promotion and mental illness and addiction prevention will be key to recovery as we move through and recover from the pandemic. Virtual programs, mental illness

prevention and early intervention programs, such as BounceBack and the Ontario Structured Therapy Program, would go a long way toward supporting people experiencing mild-to-moderate symptoms and provide them with tools to manage symptoms before they get worse.

With COVID-19, many programs have been expanded because they easily translated to the virtual format. Well-being Learning Centres, often called Recovery Colleges, for instance, saw a huge leap in terms of course enrolments. "The Recovery College going virtual has been huge and we plan to keep that indefinitely. Also, the rural communities are trying to reach out and make sure that their communities have access to our courses and know that they can log in at any time." (Christine Stewart, Executive Director, CMHA Red Deer) In other parts of the country, CMHAs were able to make their peer training and peer support services virtual, along with mental wellness courses on mindfulness, managing anxiety and depression, and managing stress during the pandemic. CMHAs expanded mental health promotion programs in response to increased requests from schools and workplaces to support the wellness of students and staff:

> *The pandemic shone a spotlight on mental health. We had an increase in calls, particularly from workplaces that wanted to address team mental health, stress management and other topics that are closely connected to mental health issues. So yes, we had an increase in calls, and we also had an increase in the number of services offered. We doubled our services; we had very strong growth in 2020 and 2021. (Participant 7, ACSM Montréal)*

Increased demand for mental health services emerging from the pandemic must be addressed through increases to sustainable, long-term and core funding for the community mental health sector. The post-pandemic world will undoubtedly entail additional societal stressors that will impact individuals' mental health, thereby further straining existing systems and the healthcare workforce. Adequate funding will be critical for the well-being of both vulnerable individuals and those providing community mental health services.

Recommendation 3: Publicly fund community-based counseling and psychotherapy

Counseling is an area of high need in our communities. Although this need existed before the pandemic, COVID-19 has created a greater demand for supports for those both with pre-existing mental illness and acute symptoms, and those with mild or moderate mental health concerns resulting from the pandemic. The greatest problems with respect to counseling relate to access: the long waitlists, the cost, and the absence of long-term supports. It is time for counseling and psychological services to become part of our publicly funded healthcare system.

Access to counseling and psychotherapy in Canada: A backgrounder [38]

In Canada, health care is governed by the Canada Health Act (1984), which has a mandate to "protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers." Currently, however, the Act only requires the public funding of treatments deemed to be "medically necessary" and those are most often delivered in a hospital or physician's office. Low-intensity and low-barrier services at the community level such as psychotherapy, counseling, and peer support are not included.

As a result, Canadian physicians are at the core of existing publicly funded mental health service delivery. Up to 80% of Canadians rely on their family physicians to meet their mental healthcare needs, but these services are limited: physicians typically offer drug therapy, emotional support, health promotion and wellness counseling, advice and referrals. Many physicians do not have the necessary supports or resources to treat people with mental illnesses or may not have the time or resources to meet the service demand. Furthermore, 14.9% of Canadians, or roughly 4.5 million people, do not have a family physician, which means that they may not have access to even basic mental health care. Some Canadians may access counseling services funded through their province or territory, but the waitlists for those services can be long. Half of Canadians wait up to a month for ongoing counseling services, while 1 in 10 can wait more than 4 months.[39]

Most Canadians needing formal psychological treatment for mild-to-moderate mental illnesses must pay out of pocket or access services through private insurance plans. It is estimated that Canadians collectively spend $950 million annually on psychotherapists in private practice, with 30% paying out of pocket. Private insurance programs often have annual limits, with coverage typically ranging from $400 to $1,500 annually – which may only cover two to eight therapy sessions. This insurance may also be lumped in with other services such as massage and physiotherapy, further reducing funds for mental health services.

With COVID-19, CMHAs that offer counseling have seen an increase in demand. Executive Director Diane Brown-Demarco notes: "In CMHA Muskoka-Parry Sound we're finding that our waitlists are growing, the amount of time people are waiting for services is growing and the most significant area that that's happening is for counseling." CMHAs also saw a higher volume of calls from people looking for support. At former CMHA Elgin-Middlesex, their supportive listening line, which provides support to those experiencing distress (not in crisis) and referrals to other services like counseling, received 35.5% more calls in March 2021.

Wait times are a significant barrier to service. In Alberta, although Alberta Health Services offers no-cost therapy, there's a long waiting list. In Saskatchewan, the waitlist to access publicly funded counseling services can range from six months to a year. Waitlists, however, are not limited to publicly funded services; in New Brunswick, in addition to the waitlists for counseling in the French and English public system, there are also waitlists for psychologists in private practice, with many refusing new clients.

During the pandemic, some CMHA branches, regions and divisions saw a boost in short-term counseling initiatives in their province or territory and in some cases within their own organization. For instance, CMHA Kelowna benefitted from a provincial grant through the Community Action Initiative, which provided a counseling grant for single session, solution-focused brief therapy (SFBT) for adults 25 and over. Some provinces saw the introduction of new provincially funded programs like the Ontario Structured Therapy Program.[40] However, these short-term counseling programs tend to focus on those with mild-to-moderate mental health concerns and are unable to meet the needs of those with more complex mental health concerns. At one CMHA, for instance:

> *We have DoorWays... they're drop-in [single session] counseling, but actually securing a consistent, regular counselor of the kind that will actually help you, whereby you build a relationship with this person and they help you go through years of trauma, chronic illness and all, that's very, very difficult to find. We do have that with Eastern Health...you call an intake line, they set you up with somebody...you go to them for a little while and then you're sort of almost forced off the caseload. (Participant 4, CMHA Newfoundland-Labrador)*

In Kelowna, B.C., affordable trauma services are particularly inaccessible, especially to those experiencing homelessness and substance use issues:

> *One area that is not well supported via counseling is around the area of trauma. You know that there are particular approaches and modalities with which to treat trauma that mainstream healthcare systems, EAP providers, often based on four to six sessions, whether it's CBT (Cognitive Behavioural Therapy) or SFBT, or whatever is not necessarily going to help with complex trauma. But trauma is pervasive when it comes to those other issues like substance use and homelessness and I don't know that I've seen accessible – certainly not affordable – access to*

counseling specifically to individuals that have experienced trauma. (Mike Gawliuk, Director of Service Delivery and Innovation, CMHA Kelowna)

Cost is a significant barrier to counseling and psychotherapy services. At CMHA Saskatchewan, a considerable number of callers are "looking for counseling but can't afford it."

They require counseling, but they're unemployed, partly ... because they require counseling and they need some tools to be able to function at a workplace. So, they don't have that kind of coverage for counseling services, they don't have an EAP program, they don't have any of that, but they also don't have spare money to spend on counseling services [....] there's the demand, but not the ability to pay for it. (Rebecca Rackow, Director of Advocacy, Research, and Public Policy Development, CMHA Saskatchewan)

Although strides have been made to increase access to counseling and psychotherapy through virtual programs like the Government of Canada's Wellness Together, and the Ontario Structured Psychotherapy Program, a critical gap remains for many Canadians hoping for in-person, long-term counseling and psychotherapy services, especially if they have complex needs that these programs don't address. Cost in the private system and waitlists for both public and private services are barriers to access. It is time to publicly fund counseling and psychotherapy services for all Canadians.

Recommendation 4: Prioritize investment in housing, income supports and food security

Greater federal leadership is needed to ensure all Canadians have access to healthy food, income supports and safe, affordable housing.

We need to:

- Protect existing affordable housing stock and establish new stock
- Provide multi-year, sustained federal funding for housing initiatives, including for supportive and transitional housing for people with mental illnesses and substance use problems
- Establish adequate income supports so that people with mental illnesses or substance use problems can have safe places to live, without fear of losing their housing, food security and other supports

Throughout the pandemic, homelessness, housing security, income supports and food security have been identified as top concerns for CMHA clients and other members of their communities. While these concerns existed before the pandemic, COVID-19 intensified them as people struggled with the financial hardships of job loss, problems with accessing income supports, lack of affordable housing and the closure of food banks and other community services, including drop-in programs. To address these issues, many CMHA branches and regions that received COVID-19 relief funding used emergency funds to expand the supports to those experiencing homelessness, housing difficulties and/or income and food insecurity. There is a clear need for greater government investment in housing and income supports to ensure that Canadians, including people with mental health and substance use problems, are adequately housed, nourished and have the necessary financial supports to help with recovery.

Housing, income supports and food security are critical social determinants of health, including mental health.

> *An individual's mental health status is dependent on far more than [...] that individual's coping skills or resilience skills. That the environment and context, I would argue probably play a bigger role in one's mental health than individual qualities or skills, and that that needs to be a theme through all of the programming in your thinking about the social determinants of health, like food security, housing, all those things. (Michael Anhorn, CEO, CMHA Toronto)*

The right to housing for all

Shelters: temporary housing that provides residents with a basic accommodation

Social housing: housing that is subsidized by a level of government

Affordable housing: housing is considered to be affordable when a household spends less than 30% of its pre-tax income on adequate shelter.[41] Affordable housing can be provided by the private, public and not-for-profit sectors and may include any housing types (i.e.: rental, ownership and cooperative ownership). It can include temporary emergency shelters, transitional housing, supportive housing, subsidized housing, market rental housing or market homeownership.

Transitional housing: service-oriented temporary housing intended as an intermediate step between homeless shelters and permanent housing. Residents can be provided supports to address mental health and/or substance use problems, life skills, education and training.

Supportive housing: is a type of housing focused on rehabilitation and community integration for people with mental illnesses and substance use problems and physical or developmental disabilities. Housing and support are linked – staff trained in social work or psychiatric rehabilitation provide various levels of support within the residences. This type of housing features group home settings, single or multiple units within a building, or scattered-site, self-contained units with low support. Supports are flexible, based on client need and on available services. They may include: case management, housing supports and peer supports, among others.

Housing remains a basic need that is inaccessible to many Canadians, predominantly due to affordability. People living with mental illnesses and substance use problems face additional challenges accessing and maintaining adequate housing. These problems are rooted in the housing system itself. For the one in five Canadians with a mental illness or substance use problem, they may require supportive or transitional housing, in addition to affordable housing. All of us – the five in five Canadians who have mental health – require access to affordable, safe, stable and long-term housing to maintain good mental health.

Many communities across Canada have a shortage of many types of housing including shelters, affordable housing, subsidized housing, supportive housing, and transitional housing, which support different needs. Laurel Taylor (Provincial Senior Lead-Project H.O.P.E., CMHA Nova Scotia) says, in Nova Scotia, "we're in a dire, dire housing shortage right now. Shelter, transitional, long term... everything is really short."

In provinces like Alberta, where rent subsidies have been clawed back, there is a lack of affordable housing for lower income Canadians, and supportive housing programs delivered by agencies like CMHA have long waitlists. Chris Babcock, of former CMHA Elgin-Middlesex in Ontario, says: "Supportive housing, that's always, always, always a focus because there's always a need and our wait lists are really long for our long-term or more permanent supportive options."

In many communities, housing problems are linked to the lack of affordable housing stock, with affordable housing being lost to private investment such as new condominium developments and short-term rentals. This increases demand for housing, and longer waitlists to access affordable units.

> *For every one affordable housing unit that comes into the marketplace [in British Columbia], three are lost to private investment... through real estate investment trusts and private investment coming in and buying up properties that have traditionally served a lower income market, and then either redeveloping them or doing the renovating and basically taking them out of the affordable market. So, we've got we've got a real challenge in that realm. (Mike Gawliuk, Director of Service Delivery and Innovation, CMHA Kelowna)*

COVID-19 has worsened housing demand and precarity in Canada. The pandemic created increased demand for housing services due to the closure of community supports and the greater risk of exposure of community members to COVID-19. For instance, in Red Deer, Alberta, people experiencing homelessness had a disproportionately high positivity rate for COVID-19. CMHA branches responded by expanding their services for those who are homeless and precariously housed. CMHA Kelowna, for instance, accessed federal Reaching Home funding to expand their outreach services for people experiencing homelessness and to assess those most at risk for exposure to COVID-19. Several branches, including CMHA Red Deer, CMHA Kelowna, and former CMHA Elgin-Middlesex set up emergency lodging in hotels or motels for those who were at risk.

The pandemic has also affected housing stock and rental vacancies in rural parts of Canada. In Muskoka, Ontario, a popular vacation destination, urban dwellers fleeing high cases of COVID-19 in urban centres fled to cottage country over the summer. This caused a loss of rental vacancies such that staff in CMHA Muskoka-Parry Sound branch were handing out tents to clients seeking emergency shelter:

> *On the weekend...there was not a single motel or hotel room available in Muskoka. They had all been booked, reserved for people who want to get out of the city. So we worked with our social services partners and we were handing out tents with sleeping bags, groceries, some clothing, and a map to a place where you could go and camp for the weekend and hopefully wouldn't get evicted...Crown Land. So that was our emergency housing solution on long weekend. (Diane Brown-Demarco, Executive Director, CMHA Muskoka-Parry Sound)*

Residents from outside the province moved to Nova Scotia, which had a low case count of COVID-19, reducing the housing stock, and affecting waitlists for affordable rental housing:

> *I think COVID also dried up our source of [rental] housing. So, pre-COVID, it was kind of we were sort of slowly getting there and then COVID happened and then we just don't have the housing stock, which really impacted a lot of our work so... A lot of our clients are waiting to get housing. So, it's almost tipping people to the point where we're supporting people while they're waiting for housing as compared to, after they get housing because of this situation." (Laurel Taylor, Provincial Senior Lead-Project H.O.P.E., CMHA Nova Scotia)*

The need for strong housing policy and government investment in housing

There is an urgent need for investment and better housing policy at all levels of government:

> *I think we need to double-down on investment in housing in this country. That is something that's going to continue to be a huge issue. And if we don't, we're going to see the outcomes, being poor mental health, and increased homelessness. So, I would suggest that the National Housing Strategy was a good start, and there is so much more to be done. (Mike Gawliuk, Director of Service Delivery and Innovation, CMHA Kelowna)*

The Government of Canada's 1996 decision to hand off responsibility for social housing to the provinces, territories, and in some cases municipalities, came with a steady decline in social housing across Canada and a significant increase in homelessness.[42] Federal housing policy should once again play a more active role in creating and maintaining social housing to ensure that Canada has a robust affordable housing stock. Since the mid-1990s, the federal government has focused its housing policy almost solely on home ownership (by providing tax benefits to homeowners, for instance), which favours private investment and consequently shrinks the rental market. At the same time, provinces and territories have not invested sufficiently in social housing to meet the need, particularly as federal transfers have been cut. While the National Housing Strategy (2017) is a welcome policy that promises federal leadership once again in supporting affordable housing, housing experts have warned that the strategy will not reach enough Canadians for whom rent is unaffordable. As housing involves federal, provincial/territorial and municipal levels of government, collaboration is required to ensure that Canadians have access to safe and affordable housing, regardless of their income or mental health status.

It is important to move beyond the one-time grant model to sustained investment in housing. This is especially true in the case of supportive housing. Long-term investments are particularly important for supportive housing programs because this is a program area with long waitlists. Supportive housing is also more expensive to operate as it requires onsite staff 24/7.[43]

The pandemic has exacerbated the rates of homelessness and created greater housing precarity among Canadians, highlighting the need for greater investments in housing.[44] Additional emergency federal investments made in the Reaching Home program are a start in meeting the needs of those experiencing or at risk of homelessness.[45] However, post-pandemic, sustained and long-term investments by governments at all levels are needed to address the systemic problems with Canada's housing system, including in urban communities, and in Indigenous communities, particularly those on reserve. Everyone must have access to safe and affordable housing.

Income supports and food security

Income supports are an important theme for CMHAs for two reasons: first, many people with mental illnesses rely on income supports of some kind – such as disability support programs – when they are unable to work, and as such, CMHAs frequently help them apply for income supports and navigate related problems. As Dave Nelson of CMHA Saskatchewan observes: "It's estimated that probably 30 to 35% of the 20,000 people on [the Saskatchewan Assured Income for Disabilities (SAID) program] are people with mental health or addictions concerns." In addition, income supports are of heightened importance to the work of CMHAs during the pandemic because COVID-19 has disproportionately impacted people with disabilities. CMHAs that provide service navigation and advocacy for people with mental health-related disabilities report receiving a greater volume of calls related to income supports. This increase was linked to the spike in unemployment at the beginning of the pandemic and to eligibility criteria for the federally administered Canada Emergency Response Benefit (CERB), which had a negative impact on eligibility for provincial disability income supports.

Even before the pandemic provincial/territorial disability supports were insufficient. Laurel Taylor (Provincial Senior Lead-Project H.O.P.E., CMHA Nova Scotia) notes:

> *An individual in Nova Scotia who is unable to work due to mental health will get a grand total of $950 to live on per month. So that definitely keeps people unwell, where most of your money goes towards your rent and then there's no funds for food or socializing or anything else.*

Several CMHAs report common claw backs and cuts to disability supports in their provinces over the last few years.

> *Some individuals [in Alberta] are only receiving less than $900 a month, and with the monthly rental rate being about $800, I'm not exactly sure…where the province thinks these folks are going to live and how they're going to live. (Participant 5, CMHA Edmonton Region)*

Due to the high volume of calls regarding the SAID program, CMHA Saskatchewan conducted research along with the Disability Support Coalition and in partnership with University of Regina and the Community Engagement and Research Centre, studying the impacts of disability support cuts. They are now advocating for government to increase income supports for people with disabilities.[46]

As mentioned, the volume of calls to CMHA branches, regions, and divisions regarding income supports increased substantially with the onset of COVID-19. In April 2021, CMHA Edmonton Region received 2,870 calls relating to income support and employment needs, up from 1,211 in April 2020. While CERB undoubtedly benefited many Canadians who lost their jobs, many CMHAs found that CERB interfered with their eligibility for other income supports. Owing to early confusion about who was eligible for the CERB benefit, CMHA clients on long-term disability experienced "more stress because they didn't ... want to apply for something that would then end up biting them in the butt come tax season or affecting other more long-term sustainable benefits." (Participant 6, CMHA PEI). In Saskatchewan, CMHA found that people who received CERB in addition to provincial income supports were asked to pay CERB back, were taken off income assistance and in some cases lost their housing.

According to Dave Nelson (Senior Consultant, CMHA Saskatchewan), income supports "have got to be one of the key things. If someone has a decent income, some of these things become much less important, like housing and other kind of things, right? Poverty is a barrier to recovery."

Food security is another basic need that has been a significant problem throughout the pandemic. CMHAs report that they experienced greater demand for assistance with food.[47] When the pandemic began, many drop-in centres, community hubs and CMHA programs such as Wellness Centres (where people could access meals, clothing and other necessities) were closed and donations to food banks dried up. For the services that remained open, transportation was a barrier, given that many people were wary of using public transit for fear of contracting the virus. Other communities report an increase in the price of groceries and the overall cost of living during COVID-19.

CMHAs responded by expanding existing programs or developing new ones to address the problem of food security in their communities.

> *We realized early on that food security was a huge issue, because the food services that our clients relied on were suddenly closed. Even for a while the food bank was closed. So, we started a food box program, added to our services. We already had a small food box program for one of our programs, but we expanded it significantly to ensure that our clients' basic need for food was met. (Michael Anhorn, CEO, CMHA Toronto)*

Others altered their service model. For instance, former CMHA Elgin-Middlesex, which provides meals to clients across all services and outreach sites, adapted their service:

People weren't able to come and get a meal, but what we were able to do was adapt and modify how we made meals for people and increased the amount of meals that we were able to provide at outreach sites. In our rural areas, we'd make meals and people would deliver them, do a knock and check to see how things were going." (Chris Babcock, Director-Quality, Performance and Risk, former CMHA Elgin-Middlesex).

CMHA Muskoka-Parry Sound used emergency COVID-19 relief funds from community partners to provide clients with $25 grocery cards. According to Executive Director Diane Brown-Demarco, the branch also "really worked hard with our social services to make sure that we could get supplies to people, whether it was food, clothing, blankets or harm reduction supplies. They were really trying to be as creative as possible to meet the needs of people out in the community."

Conclusion

Community mental health care providers are telling us that we are on the precipice of a tsunami wave of mental health problems. The pandemic has exposed and worsened cracks in our mental health system. The federal government has the responsibility, resources and capacity to once and for all integrate mental health into our universal public health system.

> *It's time for mental health care to be part of our universal health care planning [...] people shouldn't be dependent on either using the private, the public system or paying out of pocket. (Participant 6, CMHA PEI).*

The encouraging message emerging from this research is that we know what is needed to fundamentally fix our system. CMHA recommends:

- Increasing funding and strengthening the capacity of core community mental health and addictions services and supports
- Increasing support for mental health promotion and mental illness and addictions prevention programs and strategies
- Publicly funding community-based counseling and psychotherapy
- Prioritizing investments in the social determinants of health, such as housing, food and income security.

Implementing these recommendations will require bold leadership, political will, and collaboration across jurisdictions and political stripes. There are concrete opportunities on the radar to realize these changes, including the creation of new federal Ministerial mandates focused on mental health and addictions and housing, a proposed Canada Mental Health Transfer, and the creation of national mental health service standards, among others.

These opportunities must be underpinned by robust accountability mechanisms, dedicated and sustainable funding, reconciliation, human rights principles, and a critical intersectional lens, all with a view to achieve lasting, long-term change.

This paper recognizes the critical role that community mental health organizations play in delivering essential mental health services and supports to Canadians. It is time to better fund, support and integrate our services within our healthcare system.

Ours is an evidence-based and powerful case that now is the time to invest in mental health. It is informed by – and dedicated to – the people delivering community-based mental health services on the frontlines of the COVID-19 pandemic. If we don't act now, the health and well-being of Canadians may continue to deteriorate, and those of future generations may be at risk. With the right investments and strong collaboration across governments, there is still time to avoid a tsunami.

References

1. CMHA conducted four rounds of a cross-sectional monitoring survey on the impacts of COVID-19 on mental health in Canada led by academic researchers from the University of British Columbia (UBC) in partnership with Maru/Matchbox. Nearly half (46%) of Canadians reported being stressed or worried about coping with the prolonged uncertainty due to the pandemic, and, in the most recent round of research (late 2021), 60% of Canadians say they are stressed or worried about the emergence of new variants.
2. CMHA, University of British Columbia and maru/matchbox. 2022. Fourth round of cross-sectional monitoring survey on the impacts of COVID-19 on mental health. Canada. CMHA. https://cmha.ca/brochure/summary-of-key-findings-ubc-4/
3. This CMHA-UBC polling research on Canadians' mental health is based on self-report and therefore those who report problems with their mental health do not necessarily belong to the population that has received a clinical diagnosis.
4. Statistics Canada. 2020. Impacts on Indigenous people. https://www150.statcan.gc.ca/n1/pub/11-631-x/2020004/s7-eng.htm
5. Grad, Yonatan. August 11, 2011. "News: What will it be like when COVID-19 becomes endemic" Havard T.Chan. School of Public Health, USA. https://www.hsph.harvard.edu/news/features/what-will-it-be-like-when-covid-19-becomes-endemic/
6. Anderssen, Erin. October 8, 2021. "'Long COVID' is painful , expensive and so far, impossible to cure." The Globe and Mail, Canada. https://www.theglobeandmail.com/canada/article-long-covid-is-painful-expensive-and-so-far-impossible-to-cure/
7. Frasquilho, Diana, Margarida Gaspar Matos, Ferdinand Salonna, Diogo Guerreiro, Cláudia C. Storti, Tânia Gaspar and José M. Caldas-de-Almeida, « Mental Health Outcomes in Times of Economic Recession: A Systematic Literature Review," BMC Public Health 16.115 (2015); Makwana, Nikunj, "Disaster and its Impact on Mental Health: A Narrative Review," Journal of Family Medicine and Primary Care 8.10 (2019): 3090-3095.
8. Roxby, Philippa, "Psychiatrists Fear 'Tsunami' of Mental Illness after Lockdown," BBC, 16 May 2020, https://www.bbc.com/news/health-52676981; Ontario Medical Association, Responding to a Mental Health and Addiction Tsunami, May 2021. https://www.oma.org/uploadedfiles/oma/media/public/backgrounder-responding-to-a-mental-health-and-addiction-tsumani.pdf
9. Government of Canada. Public Safety Canada. October 14, 2021. "Guidance on Essential Services and Functions in Canada during the COVID-19 Pandemic." https://www.publicsafety.gc.ca/cnt/ntnl-scrt/crtcl-nfrstrctr/esf-sfe-en.aspx
10. Daley, Jason. January 30, 2019. "Syndemic: The Little-Known Buzzword That Describes Our Troubled Times." Smithsonian Magazine, USA. https://www.smithsonianmag.com/smart-news/syndemic-little-known-buzzword-describes-our-troubled-times-180971381/
11. CMHA Elgin-Middlesex. "19/20 Annual Report." https://cmhamiddlesex.ca/wp-content/uploads/2020/09/CMHA_AR_Elgin-Middlesex-2020-digital-final.pdf
12. Frederick, Tyler, Lesley A. Tarasoff, Jijian Voronka, Lucy Costa and Sean Kidd, "The problem with "Community in the Mental Health Field," Canadian Journal of Community Mental Health 36.4 (2017): 4-5.

13. Hincks, Clarence M. "The Canadian National Committee for Mental Hygiene," Canadian Medical Association 17.1 (1927): 97-98. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC406884/pdf/canmedaj00222-0113.pdf
14. The Government of Canada is also a provider of health care services to specific groups, including First Nations people living on reserves, Inuit, veterans, members of the Canadian Forces, inmates in federal penitentiaries and eligible refugee claimants. "Canada's Health Care System," Government of Canada, 17 September 2019. https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html
15. Government of Canada. August 19, 2011. "Canada Health Act – Frequently Asked Questions. https://www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/canada-health-act-frequently-asked-questions.html
16. White-Crummey, Arthur. March 19, 2019. "Mental health advocates hopeful but wary that budget will fill big gaps." Regina Leader-Post, Canada. https://leaderpost.com/news/saskatchewan/mental-health-advocates-hopeful-but-wary-that-budget-will-fill-big-gaps
17. Flood, Colleen and Bryan Thomas. 2016. "Modernizing the Canada Health Act." Dalhousie Law Journal 397, 39-2, 2016 CanLIIDocs 4119, https://canlii.ca/t/sk11.
18. Canadian Institute for Health Information, Community Mental Health and Addiction Information: A Snapshot of Data Collection and Reporting in Canada, Ottawa, ON: 2017. https://secure.cihi.ca/free_products/CIHI-comm-mental-health-en-web.pdf
19. The only fee-based programs offered by CMHA are delivered to businesses, and include programs such as Not Myself Today, workplace trainings, Peer Support Certification.
20. Canadian Institute for Health Information. Community Mental Health and Addiction Information: A Snapshot of Data Collection and Reporting in Canada. Ottawa, ON: CIHI; 2017.
21. A Common Statement of Principles on Shared Health Priorities. 2017. https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/principles-shared-health-priorities.html
22. Canadian Institute for Health Information: Shared Health Priorities. https://www.cihi.ca/en/shared-health-priorities
23. CMHA Ontario. 2021. "Investments in community mental health and addictions needed now more than ever." https://ontario.cmha.ca/wp-content/uploads/2021/02/CMHA-Ontario-2021-22-prebudget-submission-FINAL.pdf
24. Canadian Centre on Substance Use and Addiction. 2020. "Impacts of the COVID-19 Pandemic on People Who Use Substances: What we Heard." https://www.ccsa.ca/sites/default/files/2020-07/CCSA-COVID-19-Impacts-on-People-Who-Use-Substances-Report-2020-en.pdf.
25. For more information, see "Opioid-and Stimulant-related Harms in Canada, Government of Canada, September 2021. https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/.
26. Peer Support Canada. https://peersupportcanada.ca/
27. CMHA Oxford County. August 15, 2018. "Peer Support." https://cmhaoxford.on.ca/programs-services/peer-support/
28. American Psychiatric Society. "What is psychiatry?" https://www.psychiatry.org/patients-families/what-is-psychiatry-menu#:~:text=Psychiatry%20is%20the%20branch%20of,health%2C%20including%20substance%20use%20disorders

29. CMHA Toronto. August 12, 2012. "Assertive Community Treatment (ACT) Teams." https://toronto.cmha.ca/programs-services/assertive-community-treatment-act-teams/
30. See examples of case management services at: CMHA Ottawa (https://ottawa.cmha.ca/programs-services/community-support-services/), CMHA Toronto (https://toronto.cmha.ca/programs-services/case-management/) and CMHA Simcoe County (https://cmhastarttalking.ca/adult-services/case-management/#.YY02k2DMKUk).
31. Anderssen, Erin. January 18, 2020. "Half of Canadians have too few local psychiatrists, or none at all. How can we mend the mental health gap?" The Globe and Mail, Canada. https://www.theglobeandmail.com/canada/article-half-of-canadians-have-too-few-local-psychiatrists-or-none-at-all/
32. Kurdyak, Paul, Thérèse A Stukel, David Goldbloom, Alexander Kopp, Brandon M Zagorski, Benoit H Mulsant, "Universal coverage without universal access: a study of psychiatrist supply and practice patterns in Ontario" Open Medicine 8.3 (2014): 87-99.
33. Government of Canada. "Self-perceived mental health and mental health care needs during the COVID-19 pandemic." September 8, 2021. https://www150.statcan.gc.ca/n1/pub/45-28-0001/2021001/article/00031-eng.htm, and https://www.cbc.ca/news/canada/montreal/black-men-mental-health-pandemic-police-brutality-1.5893763 and https://www.cbc.ca/news/canada/toronto/toronto-covid-19-data-1.5669091
34. CMHA National. 2019. Cohesive, Collaborative, Collective: Advancing Mental Health Promotion in Canada https://cmha.ca/wp-content/uploads/2019/05/MHP-Full-Paper-FINAL-EN.pdf
35. World Health Organization. 2002. "Prevention and Promotion in Mental Health." Accessed November 11 2021: https://www.who.int/mental_health/media/en/545.pdf
36. Barry, Margaret M., and Inge Petersen, Promotion of Mental Health and Primary Prevention of Mental Disorders: Priorities for Implementation, An Evidence Brief for the WHO Inter-Country
37. Meeting on Implementation of Global Mental Health Action Plan in the Eastern Mediterranean Region (2014), accessed September 3, 2018, https://aran.library.nuigalway.ie/bitstream/handle/10379/4733/MHPPEvidenceBriefingPaper18June2014_BarryPetersen_IP.pdf?sequence=1&isAllowed=y
38. CMHA National. September 2018. "Mental Health in the Balance: Ending Mental Health Care Disparity in Canada." https://cmha.ca/wp-content/uploads/2021/07/CMHA-Parity-Paper-Full-Report-EN.pdf
39. Canadian Institute for Health Information. May 2021. "Common Challenges, Shared Priorities: Measuring Access to Home and Community Care and to Mental Health and Substance Use Services in Canada." https://www.cihi.ca/sites/default/files/document/common-challenges-shared-priorities-vol-3-report-en.pdf
40. World Health Organization. 2002. "Prevention and Promotion in Mental Health." Accessed November 11 2021: https://www.who.int/mental_health/media/en/545.pdf
41. At this time of writing, the Ontario Structured Psychotherapy Program is still in its pilot phase and thus only offered in four pilot regions of Ontario.
42. Canadian Mortage and Housing Corporation. "About Affordable Housing in Canada." https://www.cmhc-schl.gc.ca/en/professionals/industry-innovation-and-leadership/industry-expertise/affordable-housing/about-affordable-housing/affordable-housing-in-canada

43. Hulchanski, David J. "What Factors Shape Canadian Housing Policy? The Intergovernmental Role in Canada's Housing System" 2003.
44. Hulchanski
45. Young, Margot. September 6, 2019. "Policy Brief: National Housing Strategy." Broadbent Institute. https://www.broadbentinstitute.ca/margotyoung/policy_brief_national_housing_strategy
46. The federal government plays an important role in mortgage regulation and tax incentives for homebuyers; the provinces and territories fund non-market housing and assist renters through tax credits and rent control policies, and municipalities create and enforce land use planning and zoning laws.
47. CMHA National. "Round 3 of national survey shows pandemic is taking an emotional toll." May 3 2021. https://cmha.ca/brochure/round-3-of-national-survey-shows-pandemic-is-taking-an-emotional-toll/
48. The report can be accessed here http://www.saskdisc.ca/wp-content/uploads//DISC-Report-2020-1.pdf