



Canadian Psychiatric Association
Association des psychiatres du Canada

2025 Prebudget Submission

DEPARTMENT OF FINANCE CANADA: MAR. 10, 2025

Summary of Recommendations

That the federal government:

1. Work with the provinces, territories, Indigenous groups and organizations representing health-care professionals, to create and implement a pan-Canadian health human resources strategy that facilitates the identification of, and effective action on, gaps in the health-care workforce and that supports collaborative mental health care.
2. Invest additional resources into supporting mental health research that reflects the burden of mental illness.
3. Work with the provinces, territories and Indigenous groups to create and implement a pan-Canadian suicide prevention strategy with an iterative action plan that has specific priorities with measurable outcomes and ongoing evaluation; identifies and promotes effective, evidence-based population-level and individual clinical interventions; and addresses target populations overrepresented in Canada's suicide rates.
4. Enhance the psychiatric services available to people with mental illness in detention centres and prisons and put in place resources and services to provide appropriate and sufficient non-forensic, non-correctional mental health treatment to prevent the criminalization of people with mental illness.
5. In partnership with the provinces and territories, expand investments in evidence-based approaches such as Housing First to shift people from crisis and institutional services to appropriate community housing options that are flexible, available, affordable and tailored to individual needs.
6. In partnership with the provinces and territories, invest in community-based programs and support services such as assertive community treatment and intensive case management to assist people with mental illness to successfully transition from inpatient care, institutions, or homelessness to the community.

Introduction

People with severe mental illness are at high risk of poverty, homelessness and unemployment. Canada urgently needs leadership and increased, targeted investment in mental health and substance use (MHSU) services and supports.

An analysis of the 2023 bilateral agreements signed by provinces and territories examined the share of new funds invested in MHSU health. Of the possible \$2.5 billion annually (minus funding allocated to Quebec), the median percentage of new federal money for MHSU health is 5.7%; the average is 15%, with Yukon (66%) raising the mean as a significant outlier.¹ This falls far short of the promised Canada Mental Health Transfer.

Recommendation 1: Work with the provinces, territories, Indigenous groups and organizations representing health-care professionals, to create and implement a pan-Canadian health human resources strategy to facilitate the identification of, and effective action on, gaps in the health-care workforce and that supports collaborative mental health care.

Collaborative care can improve access to care (especially for marginalized and underserved populations), integrate physical and mental health care and facilitate transitions in care.² To fulfill this potential, a pan-Canadian health human resources data strategy to improve the collection, access, sharing and use of health workforce data, in conjunction with a national strategy to promote and implement effective health care teams across Canada, is required.

Recommendation 2: Invest additional resources into supporting mental health research that reflects the burden of mental illness.

One in five Canadians experiences a mental health problem or disorder in any given year and it is estimated the total cost from mental health problems and illnesses will cost the Canadian economy more than \$2.5 trillion by 2041.³

Yet, when juxtaposed to the cost of mental and brain disorders, funding for mental health research lags other areas of research internationally.⁴

In 2018/19, the Canadian Institutes of Health Research (CIHR) allocated approximately 9% of its funding to MHSU research,⁵ yet mental health and pain account for 24% of the health burden.⁶

To ensure that mental health research investments yield steady returns, “research must be funded at every level—from systems to patient-level factors—that limit the use and effectiveness of interventions, including through prevention/early-intervention strategies and therapies for those already ill.”⁷

Research priorities include substance use treatment and prevention (e.g., a national education campaign like that for tobacco), suicide prevention, corrections and the efficacy of virtual care for people with severe mental illness. Attention to the practical aspects of virtual care (e.g., digital infrastructure, digital literacy, phone access, privacy) is needed.

Recommendation 3: With the provinces, territories and Indigenous groups, create and implement a pan-Canadian suicide prevention strategy with an iterative action plan that has specific priorities with measurable outcomes and ongoing evaluation; identifies and promotes effective, evidence-based population-level and individual clinical interventions; and addresses target populations overrepresented in Canada's suicide rates.

In 2019, Canada had the sixth highest suicide rate out of the 33 countries in North, Central and South America.⁸ Further, a 2024 Senate committee report found that, despite the Suicide Prevention Framework created in 2016, suicide rates in Canada have not decreased. The report proposed changes to make the framework effective, citing many of the above elements in the CPA recommendation.⁹ The national suicide prevention action plan, released in May, updates the framework to make it more effective and is a good first step toward a pan-Canadian suicide prevention strategy with dedicated funding and buy-in from the provinces, territories and Indigenous groups.

CPA supports the collaborative nature of the action plan which establishes a committee to coordinate the efforts of 15 federal departments and builds on provincial, territorial and Indigenous-led initiatives and strategies developed in the absence of a pan-Canadian strategy. Importantly, the plan articulates specific priorities with measurable outcomes and associated performance indicators and will be regularly reviewed. The CPA supports the focus on national data collection and analysis, strengthened research and evaluation, and the development and dissemination of suicide prevention tools and resources.

The scarcity of evidence-based suicide interventions requires a coordinated approach to suicide prevention research. While CIHR funding to establish the Integrated Youth Services Network Indigenous Network is a start, this research agenda should be expanded to support new interventions and approaches, including in substance use problems, to more priority populations.

Importantly, the plan targets populations disproportionately at risk of suicide (e.g., Indigenous people, boys and men, 2SLGBTQI+, certain age and occupational groups). A focus on gender differences is also needed as factors leading to suicide can differ between men and women.⁸

CPA recognizes the jurisdictional challenges a pan-Canadian suicide prevention strategy presents. The federal government can lead by example as some of the poorest outcomes are amongst populations for which it is directly responsible.⁸ Additionally, CPA urges the federal government to use its regulatory role to develop national policies and guidelines around means restriction where there is strong evidence.

Recommendation 4: Enhance the psychiatric services available to people with mental illness in detention centres and prisons, and put in place resources and services to provide appropriate and sufficient non-forensic, non-correctional mental health treatment to prevent the criminalization of people with mental illness.

Many people with severe mental illnesses are incarcerated, partly owing to a lack of appropriate community resources, with correctional facilities becoming de facto psychiatric institutions. Some people with mental illness receive treatment only after being found Not Criminally Responsible or unfit to stand trial. Access to care for many occurs after they have been criminalized.

Indigenous people are significantly overrepresented in corrections (32% overall and almost 50% of incarcerated women),¹⁰ many of whom have complex trauma issues, substance use disorders and a history of hospitalizations. Jails have inadequate supports for aging inmates, who have dementia or physical health issues. Those with cognitive impairments frequently become permanent forensic patients, often with no hope they will become fit to stand trial.

The lack of services and supports in prisons for people with mental illness results in unacceptable seclusion rates and a lack of appropriate treatment. There are few places within the correctional system where mental health patients found incapable can be treated involuntarily. It is difficult to find them treatment outside the facility due to the double stigma of mental illness and criminality.

In addition to better resourcing the community mental health system to prevent criminalization, the CPA recommends striking a commission to review the effects of deinstitutionalization and hold provincial and territorial governments accountable for appropriate hospital and community resources.^{11,12}

Additional dedicated funding for research and education should be embedded within federal correctional health services budgets.

Recommendation 5: In partnership with the provinces and territories, expand investments in evidence-based approaches such as Housing First to shift people from crisis and institutional services to appropriate community housing options that are flexible, available, affordable and tailored to individual needs.

More than 500,000 Canadians living with a mental illness are inadequately housed. Of these, up to 119,000 are homeless.¹³ Investing in supportive housing creates savings across the health care, social services and justice systems. The At Home/Chez Soi national housing study found that every \$10 invested in supportive housing resulted in an average savings of \$21.72. In addition, At Home/Chez Soi participants reduced their use of services, and outpatient visits to hospitals.¹⁴

Finding adequate housing is especially challenging for people with disabilities due to stigma and discrimination, and the inadequate income supports from current social assistance programs. The new Canada Disability Benefit, as currently funded and defined, falls far short of its potential to address this gap.

The shortage of public and private housing across Canada makes it imperative that the federal government incentivize building supportive housing for people with mental illness.

Recommendation 6: In partnership with the provinces and territories, invest in community-based programs and support services such as assertive community treatment and intensive case management to assist people with mental illness to successfully transition from inpatient care, institutions, or homelessness to the community.

Patients with complex needs do well with ACT and ICM teams which work hand in glove with supportive housing. Yet wait times in some jurisdictions can be a year or longer to access this model of care.¹⁵

About the CPA

Founded in 1951, the Canadian Psychiatric Association is the national voice of Canada's psychiatrists and psychiatrists-in-training and is the leading authority on psychiatric matters in Canada.

References

1. Leduc SM. Overpromised and underdelivered: Analysis of federal mental health care investments in the 2023 Working Together bilateral agreements. Toronto (ON): Canadian Mental Health Association. Forthcoming 2024.
2. Kates N, Sunderji N, Ng V, et al. [Collaborative mental health care in Canada: challenges, opportunities and new directions](#). Can J Psychiatry. 2023 May;68(5):372-398.
3. Mental Health Commission of Canada (MHCC). Making the case for investing in mental health in Canada. Ottawa (ON): Author; 2013.
4. Wykes T, Haro JM, Belli SR, et al. Mental health research priorities for Europe. Lancet Psychiatry. 2015;2(11):1036—1042.
5. McGrath PJ, Asmundson GJG, Blackstock C, et al. Easing the disruption of COVID-19: supporting the mental health of the people of Canada. Ottawa (ON): Royal Society of Canada; 2020.
6. Vigo DV, Kestel D, Pendakur K, et al. Disease burden and government spending on mental, neurological, and substance use disorders, and self-harm: cross-sectional, ecological study of health system response in the Americas. Lancet Public Health. 2019;4(2):e89-e96.
7. Lewis-Fernandez R, Rotheram-Borus MJ, Trotter Vetts V, et al. Rethinking funding priorities in mental health research. Br J Psychiatry. 2016;206(6):507—509.
8. Lange S, Cayetano C, Jiang H, et al. [Contextual factors associated with country-level suicide mortality in the Americas, 2000–2019: a cross-sectional ecological study](#). Lancet Reg Health Am. 2023 Feb 23.
9. Senate, Standing Committee on Social Affairs, Science and Technology. [Doing what works: rethinking the federal framework for suicide prevention](#). June 2023.
10. Office of the Correctional Investigator. Annual report 2022-2023. Ottawa (ON): Author; 2023.
11. Chaimowitz GA. [The criminalization of people with mental illness](#). Can J Psychiatry. 2012(a);57(2):Insert 1-6.
12. Chaimowitz GA. [The treatment of mental illness in correctional settings](#). Can J Psychiatry. 2012(b);57(2):Insert 1,1-2.
13. Trainor J, Taillon P, Pandalangat N. Turning the key: assessing housing and related supports for persons living with mental health problems and illness. Calgary (AB): Mental Health Commission of Canada; 2011.
14. Goering P, Veldhuizen S, Watson A, et al. National At Home/Chez Soi final report. Calgary (AB): Mental Health Commission of Canada; 2014.
15. Gratzner D. A crisis of neglect: how society can help those with mental illness. Globe and Mail. 2023 July 14.