IN FOCUS >

Mental Health in CANADA

Population: 41,012,563

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

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1.2	MHASU Strategy	Policy	Out of date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

*National average

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

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

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

POLICY

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

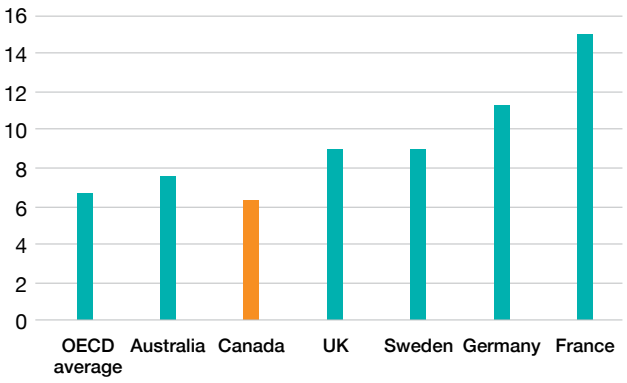
Mental Health Scoreboard

Funding

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

Chart 1

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



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

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

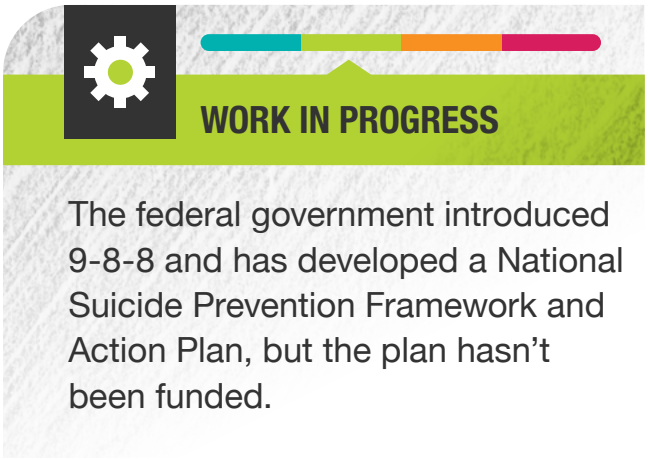
Dedicated federal spending for mental health is far lower, however. In the lead up to the 2021 election, the Liberal Party of Canada, which went on to form a minority government, campaigned on

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

Strategy

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

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



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Policy response to the toxic drug crisis

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

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

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

NOTEWORTHY

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

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

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

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

POPULATION MENTAL HEALTH

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

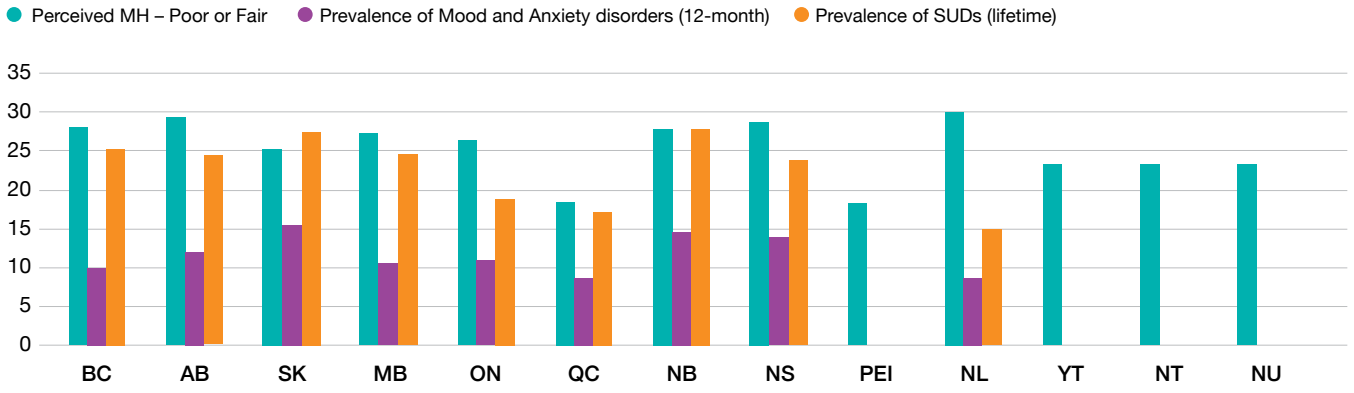
HIGH ALERT

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

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

Chart 2

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



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

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

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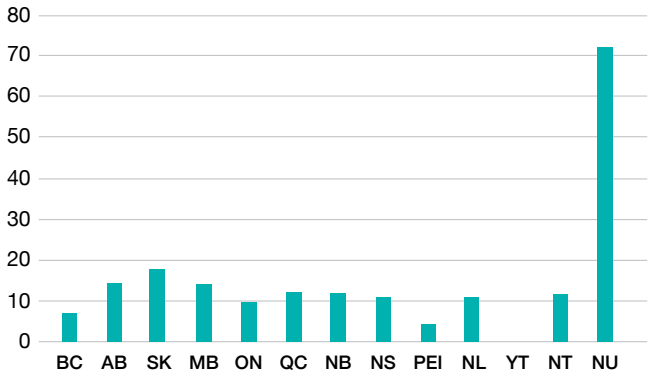
It is important to measure rates of death by suicide. Not only do these numbers represent a tragic loss of life, but deaths due to suicide are also wholly preventable. The rates of death by suicide can provide insight into the state of mental health and mental illnesses in a population and the progress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

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

Chart 3

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

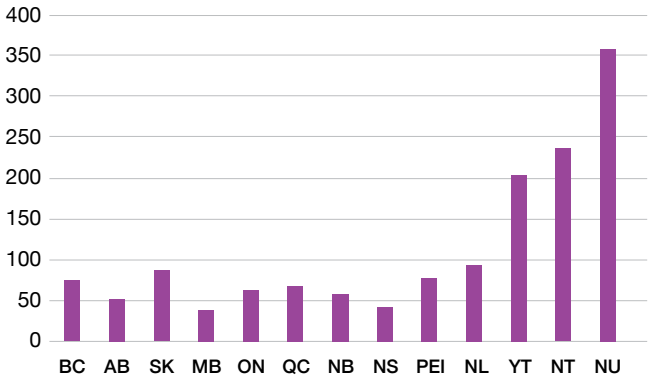


Source: Government of Canada. (2023). Suicide, self-harm, and suicide-related behaviours in Canada (2020): Suicide mortality

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

Chart 4

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



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

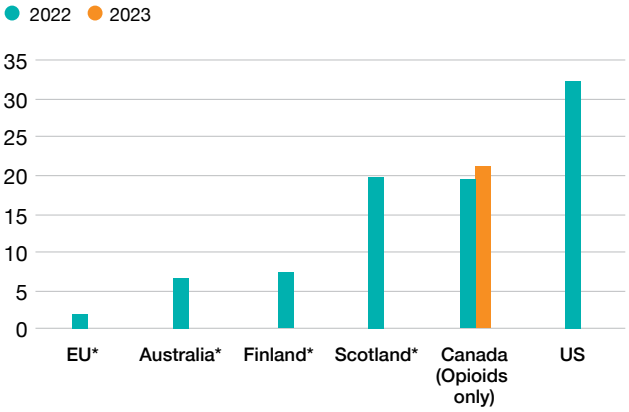
Equally concerning are the harms due to alcohol and the unregulated toxic drug supply which continue to rise. In 2023, Canada recorded 20.8 deaths due to opioid poisoning per 100,000 people, an increase from the rate recorded in 2022, which was 19.6 deaths per 100,000.[42] That's 8,049 lives lost to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

IN FOCUS: CANADA

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

Chart 5

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



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

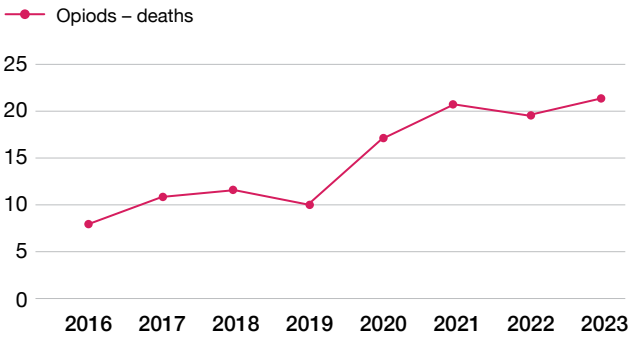
EMCDDA, European Drug report, 2022.

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

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

Chart 6

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



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

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

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

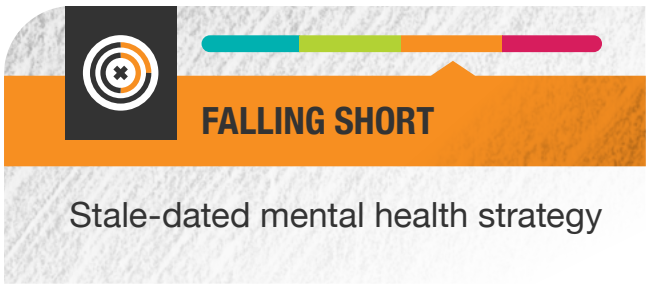


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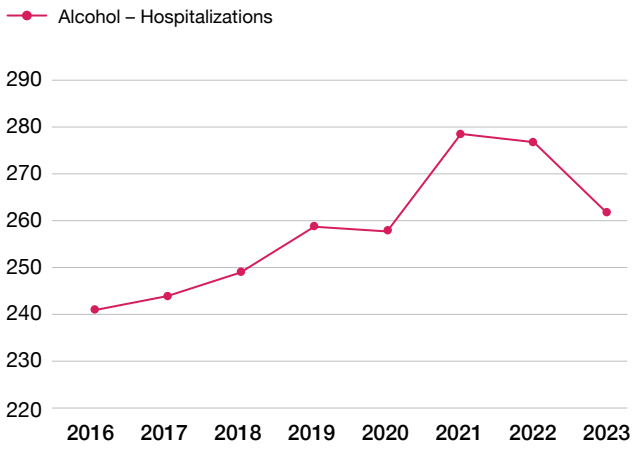
Chart 7

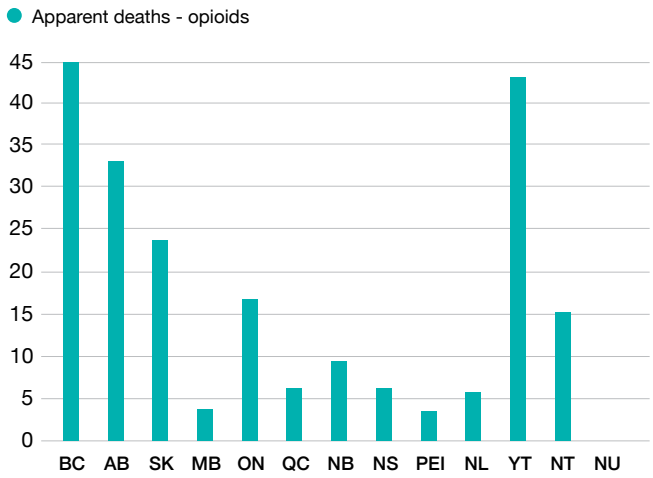
Trends: Hospitalizations caused entirely by alcohol in Canada from 2016-2023, rate per 100,000



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

Chart 8

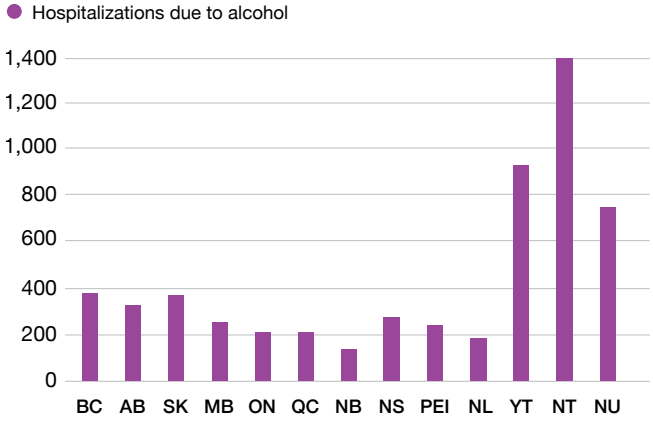
Apparent deaths due to opioid toxicity, rate per 100,000 by province and territory (2023)



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

Chart 9

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



Source: Canadian Institute for Health Information. (2024)

SERVICE ACCESS

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

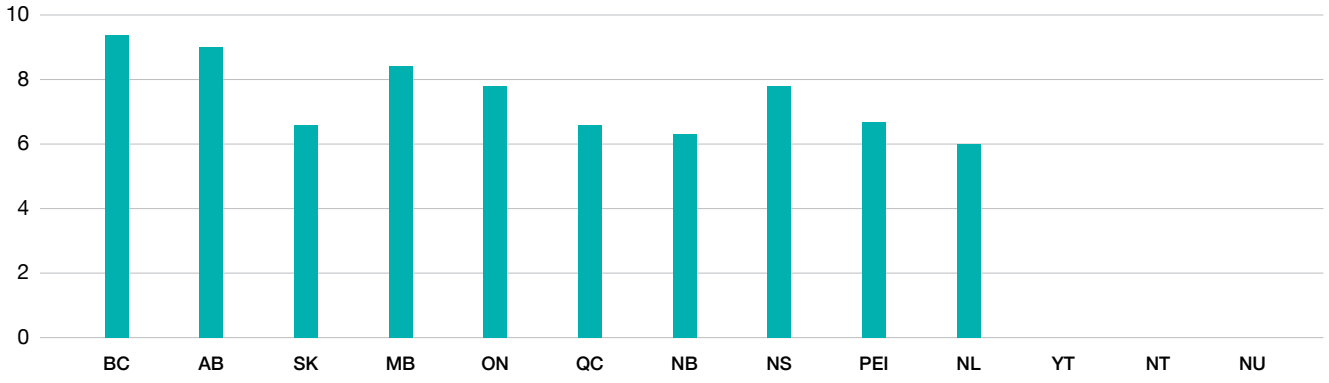
As already noted, we are cautious about making comparisons between Canada and international jurisdictions because of differences among our healthcare systems and standards for performance measurement. This is particularly true for service access data: some studies are at a regional rather than national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

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

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

Chart 10

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



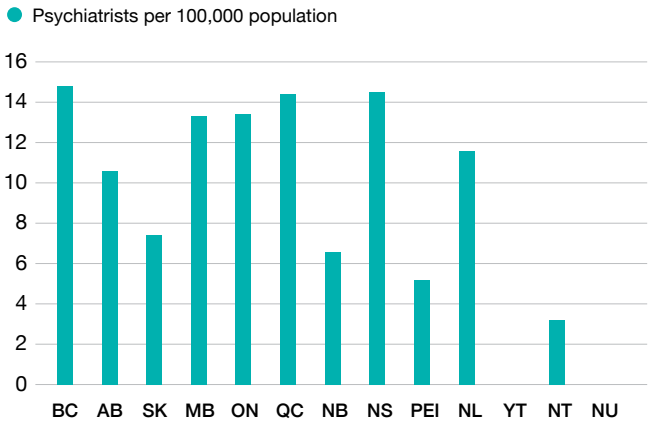
Source: Statistics Canada. (2023). Canadian Community Health Survey – Annual Component; Mental health characteristics: Perceived need for mental health care.

IN FOCUS: CANADA

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

Chart 11

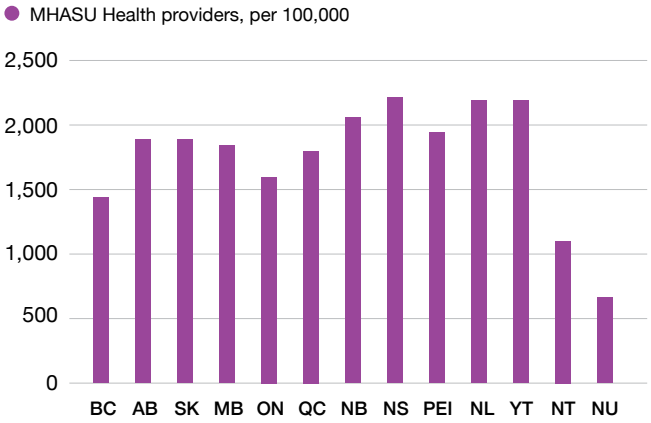
Distribution of psychiatrists per 100,000 population, by province and territory (2019)



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

Chart 12

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

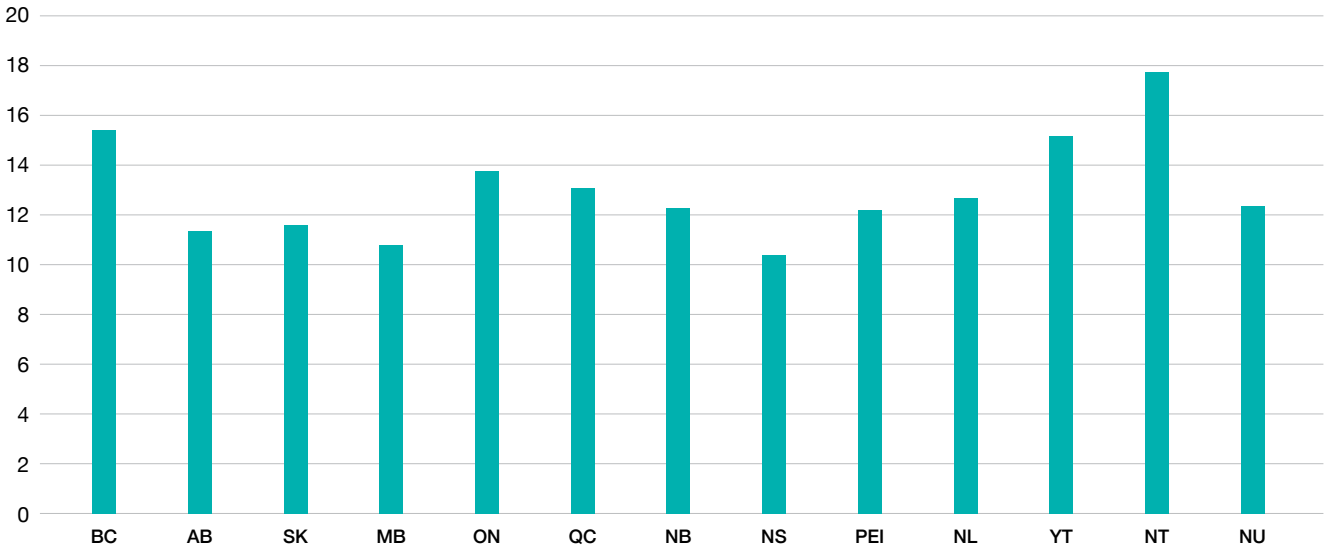


Source: Canadian Institute for Health Information. (2021). A profile of selected mental health and substance use health care providers in Canada, 2021.

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

Chart 13

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



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

THE SOCIAL DETERMINANTS OF HEALTH

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

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

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

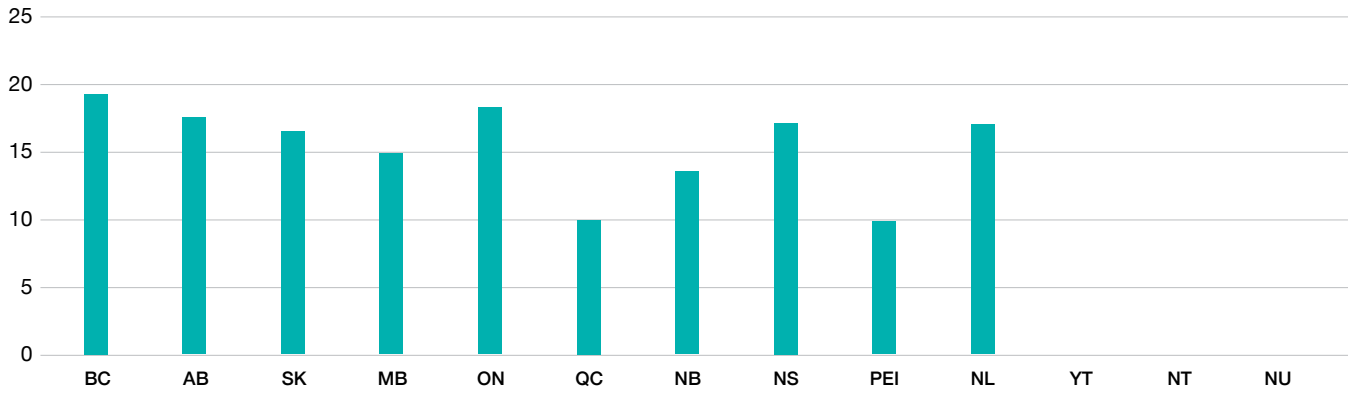
Housing

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

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

Chart 14

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



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

IN FOCUS: CANADA

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

WORK IN PROGRESS

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

Poverty and Employment

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

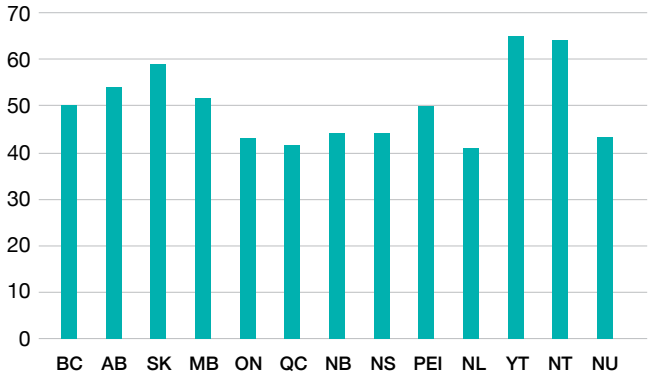
NOTEWORTHY

Financial benefits during the pandemic significantly lowered the poverty rate.

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

Chart 15

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



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

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

NOTEWORTHY

Commitment to cut poverty in half by 2030.

WORK IN PROGRESS

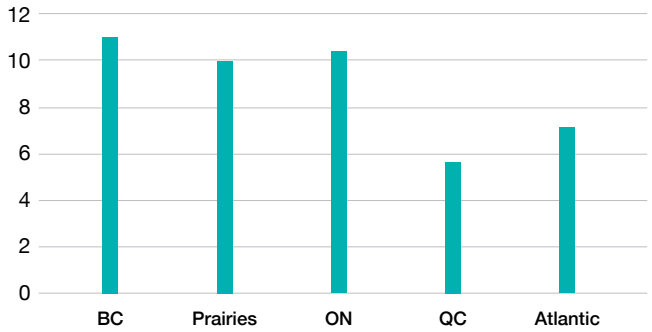
The new Canada Disability Benefit must ensure that people with disabilities have enough financial support to live adequately.

STIGMA AND DISCRIMINATION

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

Chart 16

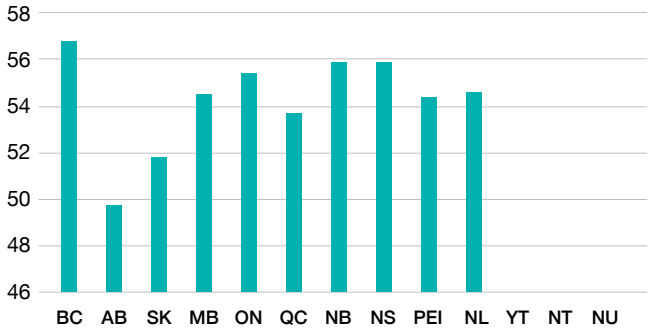
% reporting poor-to-fair mental health who experience discrimination and victimization, by province and territory (2019)



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

Chart 17

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



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

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

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

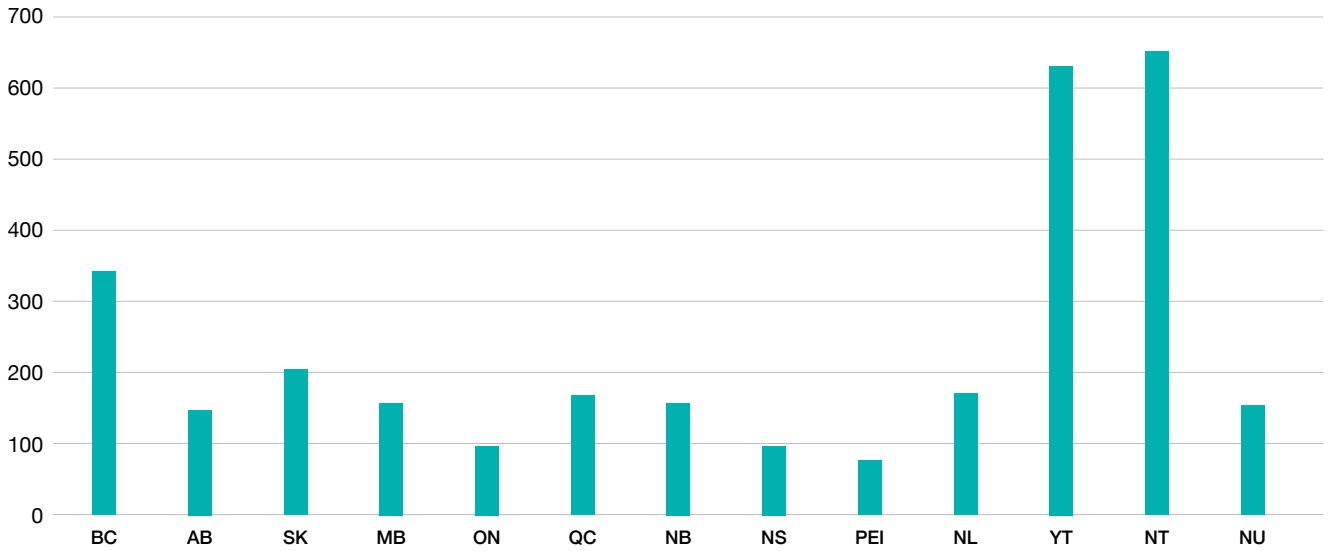
IN FOCUS: CANADA

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

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

Chart 18

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



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