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The Mental Health and Substance Use Health Standardization Roadmap

Prepared by the National Mental Health and Substance Use Health Standardization Collaborative

Standards
Council
of Canada

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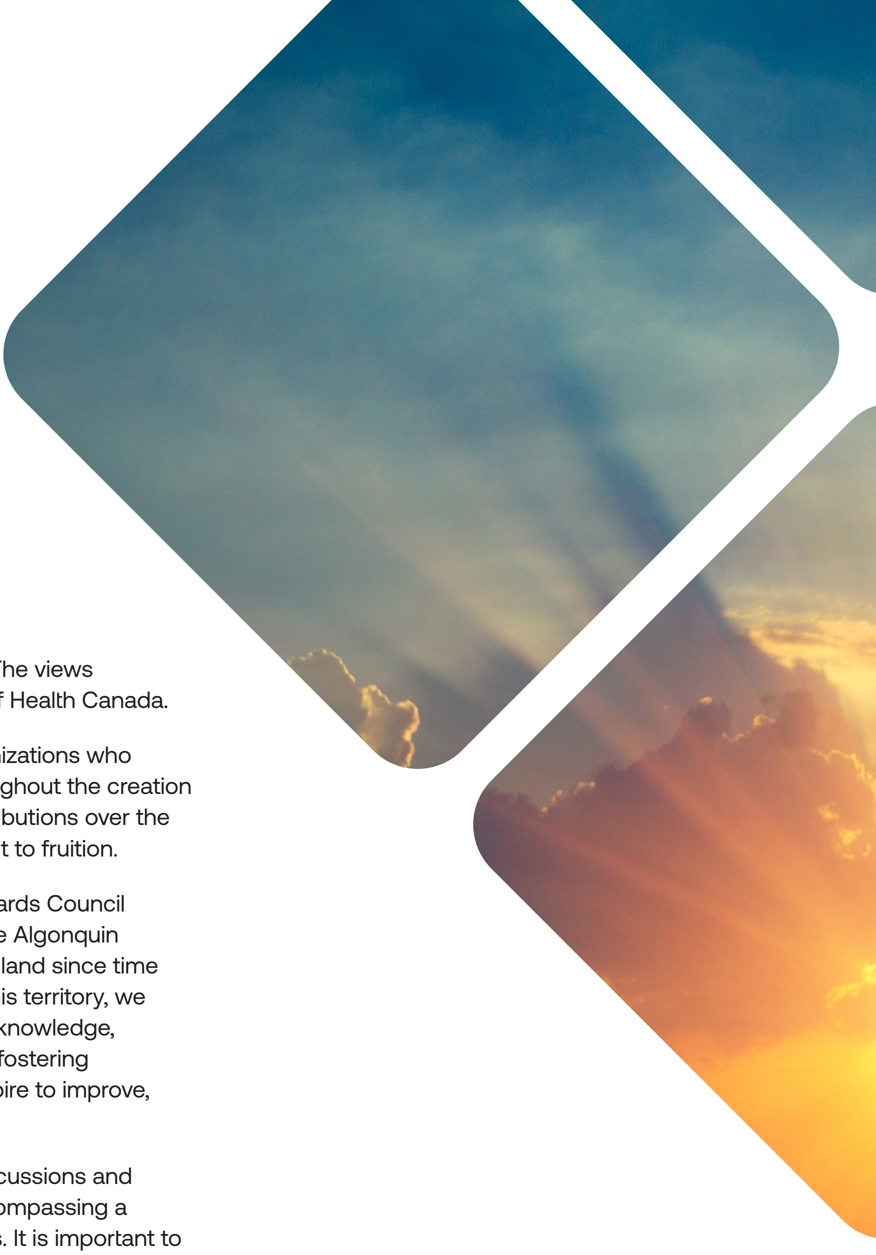

Acknowledgements

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We extend sincere appreciation to all individuals and organizations who generously offered their expertise, input, and support throughout the creation of this Roadmap. Their dedication, engagement, and contributions over the past year have been instrumental in bringing this document to fruition.

We respectfully acknowledge that the offices of the Standards Council of Canada reside on the traditional, unceded territory of the Algonquin Anishnaabe people, who have inhabited and cared for this land since time immemorial. Grateful for the privilege of being present in this territory, we recognize Indigenous Peoples as custodians of traditional knowledge, enriching our society through their wisdom. Committed to fostering respectful partnerships with all Indigenous Peoples, we aspire to improve, seek collective healing, and pursue genuine reconciliation.

The Roadmap represents a synthesized compilation of discussions and input from those actively engaged in its development, encompassing a range of perspectives, including potentially divergent views. It is important to emphasize that the Roadmap does not seek to assert one view as definitive or dismiss others as incorrect. Rather, its purpose is to authentically capture the multifaceted nature of mental health and substance use health in Canada, while also underscoring the pivotal role of standardization in fostering ongoing improvement within Canada's healthcare system.

"Every human being has the right to the highest attainable standard of physical and mental health. Countries have a legal obligation to develop and implement legislation and policies that guarantee universal access to quality health services and address the root causes of health disparities, including poverty, stigma and discrimination.[1]*"*

– World Health Organization (WHO)

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[1] https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health

Message from the Co-Chairs of the National MHSUH Standardization Collaborative

As we embarked on our journey with the Mental Health and Substance Use Health (MHSUH) Collaborative, it became clear that dismantling entrenched assumptions and biases within existing systems was imperative. Recognizing the need to address past harm, systemic racism, and stigma, our primary objective with this Roadmap is to demonstrate how standardization processes and tools can empower MHSUH organizations to improve the quality of treatment and support for all those in need, even with limited resources.

Our collaborative endeavor is dedicated to shaping the future of MHSUH care by amplifying diverse voices and experiences. We remain steadfast in our commitment to informing standards and a roadmap that authentically reflects the needs and aspirations of all interested parties. Throughout this process, we have remained guided by key principles such as person-centred care and equitable access to care. While clinical guidelines remain indispensable, our focus extends beyond individual treatment protocols to address systemic challenges and avenues for improvement.

Furthermore, we must not lose sight of critical considerations such as planning, funding, and performance assessment. These factors will significantly influence the implementation and evaluation of the Roadmap

Over the past year, the Collaborative has diligently identified areas ripe for collaboration and innovation. Our working groups, convening virtually, delved into key issues facing MHSUH today. Efforts with First Nations, Inuit, and Métis communities and racialized people(s) underscored the importance of culturally safe care and equity-driven approaches.

Moving forward, establishing trust in our MHSUH services is paramount to safeguarding the health, safety, and well-being of people living in Canada. Standardization is crucial for enhancing the quality and consistency of MHSUH systems and services, with recommendations focusing on cultural safety and accessibility to transform the sector into a more inclusive and responsive system.

We extend our heartfelt gratitude to the members of the Collaborative for their courage in engaging in candid and challenging conversations and for their unwavering dedication to improving MHSUH services for all people living in Canada. We also express our appreciation for the invaluable support and guidance of our Secretariat, the Standards Council of Canada.

Chi miigwech.
Brian and Carol

Dr. Carol Hopkins, Chief Executive Officer, Thunderbird Partnership Foundation
Dr. Brian Rush, Emeritus Scientist with the Institute for Mental Health Policy Research at the Centre for Addiction and Mental Health (CAMH)

Message from the CEO, Standards Council of Canada

In March 2022, the Government of Canada committed to collaborating with the Standards Council of Canada (SCC) and other stakeholders to establish national standards for the mental health and substance use health (MHSUH) systems and services and to develop a comprehensive Roadmap. This initiative led to the formation of the National MHSUH Standardization Collaborative, aimed at gathering diverse input.

At SCC, we prioritize addressing societal needs through standardization. Our expertise lies in fostering collaboration among various interested parties to develop progressive standards and tools that align with Canadian, First Nations, Inuit, and Métis values and priorities.

The National MHSUH Standardization Collaborative was established to coordinate standardization efforts nationwide. Over two years, we engaged with over 300 people from government, First Nations, Inuit, and Métis governments and communities, experts, academics, researchers, academic and research bodies, people with lived and living experience, industry, providers, professional associations, pan-Canadian health organizations, and standards development bodies.

The resulting Roadmap identifies key issues, gaps in standardization, and offers recommendations to address them, serving as a resource for navigating the future of MHSUH in Canada.

Despite challenges posed by the pandemic, our collaborative effort persisted, fueled by the dedication of participants from diverse backgrounds. The strength of our endeavor lies in the breadth of perspectives contributed.

To potentially implement these recommendations, SCC acknowledges the importance of partnerships and potential funding. Standardization, if effectively applied, may promote excellence, and enhance access to the safest products, systems, and services. SCC remains open to collaborating with standards development organizations and other interested parties, recognizing the potential impact of leveraging our convening power to explore solutions aligned with the Roadmap's twenty-four (24) recommendations.

We extend our gratitude to all involved in this endeavour and look forward to continued collaboration in advancing the health and safety of all people living in Canada.

Chantal Guay

Ms. Chantal Guay, Ing., P.Eng., FCAE, ICD.D

Executive Summary

The purpose of this Roadmap is to describe the existing and envisioned national standardization landscape for mental health and substance use health (MHSUH) systems and services in Canada. It aims to identify areas for improvement and propose actionable recommendations to bridge existing gaps and explore new avenues for standardization.

MHSUH affects all segments of society, and populations across the socioeconomic spectrum. In 2019 and 2021, the Prime Minister's mandate letters to the Minister of Health and the Minister of Mental Health and Addictions emphasized establishing national standards for MHSUH systems. The COVID-19 pandemic exacerbated MHSUH challenges, underlining existing gaps in services and the urgent need for action. Despite efforts outlined in the 1986 Ottawa Charter, consistent access to MHSUH treatment and support remains elusive nationwide. Six areas for standardization were identified in alignment with 2017 provincial and territorial shared health priorities, including: integration of MHSUH in primary care settings, digital MHSUH apps, integrated youth services, integrated MHSUH services for Canadians with complex needs, substance use treatment centres: withdrawal management services, and substance use health workforce: prescriber competencies for non-addictions providers.

In 2022, with support from Health Canada and in alignment with the government's commitment, the National MHSUH Standardization Collaborative was established to develop a comprehensive Roadmap for MHSUH standards. This initiative aimed to identify key issues and gaps in standardization to improve service delivery and treatment outcomes. The Collaborative attempted to ensure inclusive participation from all people living in Canada to maintain balanced representation across the MHSUH continuum, leveraging its diverse membership to address complex standardization issues.

Focused on four priority areas—Foundation and Integration, Primary Health Services Integration, Children and Youth, and People with Complex Needs, including substance use health—the Collaborative's efforts were guided by the priorities identified by provinces and territories. Additionally, SCC facilitated five separate consultations to broaden engagement with people living in Canada on features or principles for MHSUH. These consultations provided opportunities to gather perspectives from the public at critical junctures during the Roadmap's development, aiming to achieve a national perspective on standardization in MHSUH. Furthermore, the engagements included specific outreach to Indigenous communities, an anti-racism focus group, discussions on substance use health, and evaluations of conformity assessment and accreditation programs.

When you read the Roadmap in its entirety, three broad themes become evident:

1. **Person-Centred Care and Collaboration:**[2] Establishing standardization solutions to tailor care to individual needs while fostering collaboration among interested parties to ensure holistic support.
2. **Equity and Inclusion:** Addressing systemic disparities and promoting cultural competency and health condition/disease state competency to ensure equitable access to MHSUH care for all individuals.
3. **Continuum of Care and System Integration:** Establishing standardized protocols to facilitate seamless transitions between different healthcare services and settings.

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[2] This includes psychosocial rehabilitation (PSR).

Twenty-four (24) key issues and resulting recommendations were identified by the Collaborative:

- Stigma Free and Consensus-based Terminology and Language
- Different Types of Evidence and Experiences
- Accountability and Evaluation Mechanisms
- Human Rights and Substantive Health Equity
- Harm Reduction Principles and Approaches
- First Nations, Inuit, and Métis Knowledge Systems and Inherent and Treaty Rights
- Privacy and Confidentiality Related to Mental Health and Substance Use Health
- Quality of Health Services Achievable by Effectively Addressing the Social Determinants of Health
- Workforce Health, Trainings and Competencies
- Continuity and Transition of Care
- Timely Access to MHSUH Care
- Continuum of Care
- Quality Assurance for Digital MHSUH Applications
- Behavioural and Technical Competencies and Workforce Development for Those Involved in MHSUH Care for People in Canada
- Mobile Crisis Response/Mobile Crisis Care
- Youth-Partnered Care
- Promoting Access to Equitable and Culturally- and Identity-Affirming Youth-Partnered Care
- Systematic Screening Processes and Tools for Youth
- Communication and Collaboration Across the Continuum of Care for Children and Youth
- Substance Use Health Care for Young People
- Support for Caregivers Who Support Young People
- Person-Centred Healthcare and Co-creation of Care
- Valuing the Role of Families/Caregivers in Supporting People with Complex Needs, and Acknowledging their Own Needs for Services/Supports
- Continuum of Care for Complex Needs

This Roadmap is an **invitation to action**. Partnerships among all interested parties will be imperative for advancing MHSUH infrastructure, sharing best practices, and increasing client decision-making over treatment, choice of services and approach to care. All parties can contribute to each of the areas listed below:

- Funding the development and implementation of national standards and incorporating them into policy frameworks.
- Advocating for centring Indigenous perspectives and prioritizing cultural safety in standards and practices.
- Advocating for person-centred standards and supporting their adoption.
- Informing evidence-based standards and protocols.
- Embracing and implementing national standards within organizations.
- Collaborating to develop, refine, and support the adoption of national standards.

For more information on how to use this Roadmap or to get involved in standardization, please contact the Standards Council of Canada at info@scc.ca.

How to Use this Report

About Standards and Conformity Assessment

Standards serve as comprehensive guidelines, ensuring consistent practices and technical requirements across diverse fields, providing a robust structure for healthcare. They help improve service quality, identify gaps, enhance safety, and increase efficiency for both providers and the public.

Conformity assessment (certification and accreditation) determines whether products, services, or systems align with standards. In healthcare, it occurs at the organization or program level, ensuring adherence to client care and safety standards. SCC, as Canada's representative in standards and accreditation, ensures conformity assessment bodies meet stringent standards, instilling confidence domestically and globally.

Standardization is the development and application of standards. It includes:

- the work of the committees that develop standards
- the publication of standards by standards development organizations
- the recognition of standards by national standards bodies such as SCC
- the application of standards by businesses, suppliers and customers
- the verification that products or services conform to applicable standards (conformity assessment)
- the accreditation of organizations that provide conformity assessment services
- the use of standards and conformity assessment as an element in public policy as well as in international trade

In Canada's MHSUH sector, standards and conformity assessment drive quality, safety, and effectiveness, establishing evidence-based guidelines, promoting interoperability, and enhancing client care and treatment outcomes.

About the Collaborative

Established in 2022, the National MHSUH Standardization Collaborative (referred to also as "the Collaborative") brought together over 300 stakeholders from government, First Nations, Inuit, and Métis Inuit governments and communities, experts, academics, researchers, academic and research bodies, people with lived and living experience, industry, providers, professional associations, and pan-Canadian health organizations, and standards development bodies. Their goal was to develop a comprehensive Roadmap identifying key issues and gaps of existing and needed standards for MHSUH, in support of enhancing service delivery and treatment outcomes. Participation was open to all people living in Canada, striving for balanced representation; the Collaborative's strength lay in its diverse membership and its commitment to addressing complex standardization issues.

Reading the Roadmap

This Roadmap reflects discussions held by members of the Collaborative since its establishment, covering a range of topics related to MHSUH.

The Roadmap is intended for every individual in Canada, recognizing healthcare as a fundamental right. In 2021, the federal government established the position of Minister of Mental Health and Addictions and Associate Minister of Health, emphasizing the importance of addressing health inequities, particularly for marginalized communities, including Black people, Indigenous people, and People(s) of Colour (BIPOC), among others, while working to ensure that MHSUH care is treated as a full and equal part of our universal healthcare system. Despite universality being a condition of federal health care transfer in the Canada Health Act, equitable access remains a challenge in Canada.

This Roadmap is designed for government bodies, regulatory agencies, industry, academia, and the public seeking guidance on standardization strategies for addressing MHSUH issues. It aims to navigate important discussions shaping our future, serving as a source to allocate resources efficiently for participation in planning and developing standards and related research activities. It assumes that readers are interested parties directly impacted by MHSUH issues, possessing a basic understanding of the key strengths and challenges in these areas.

The development of the Roadmap draws upon the expertise of its contributors. Canada's MHSUH systems and services face challenges such as fragmented services, pervasive stigma, limited access to care, workforce shortages, needed skills and competencies in this specialized area of health care, and disparities in service provision, necessitating comprehensive reforms. Despite the challenges facing Canada's MHSUH systems, there are notable positives regarding actions taking place across the country. These include increased awareness and acknowledgment of MHSUH issues, efforts to reduce stigma through public campaigns and education, and prioritization of MHSUH in national healthcare agendas, to name a few.

Standards and conformity assessment can play a vital role in addressing this crisis by providing a framework for consistent quality of care and service delivery for all people living in Canada. Conformity assessment mechanisms, such as accreditation and certification processes, promote accountability and quality improvement within the healthcare system, enhancing coordination of care and continuity for clients, including evaluation / feedback from the user and outcome measures on the services to inform or improve services, to ensure needs are being met.

The first section of the Roadmap provides the perspectives of those who participated in its development, including outcomes from an Indigenous engagement consultation, public consultations, an anti-racism focus group, an analysis of the spectrum of substance use health, and evaluations of conformity assessment and accreditation programs.

The second section outlines twenty-four (24) key issues and resulting recommendations identified by the Collaborative, emphasizing the impact of MHSUH on individuals and organizations, and highlighting unique national experiences with mental health and substance use health issues.

The third section summarizes recommendations provided by members of the Collaborative and next steps to transition the Roadmap from theory to action, putting standards and conformity assessment into practice.

It is important to keep in mind that standardization and conformity assessment are just one set of tools for advancing system transformation. The roadmap weaves back and forth between these distinct but interrelated lenses.

Annexes provide detailed information on the Collaborative's work, including analysis of working groups, task groups, Indigenous engagement and public consultation outcomes, membership details, a glossary, methodology, and a detailed standardization landscape.

Standardization and Mental Health and Substance Use Health in Canada

Background

According to data from 2022, over 5 million Canadians (18% of the population) aged 15 and older met the diagnostic criteria for a mood, anxiety, or substance use disorder in the previous 12 months.[3] The COVID-19 pandemic exacerbated strains on MHSUH systems and services, exposing gaps in services and treatment access, highlighting the urgent need for enhanced services.

Standardization is vital for improving the quality and accessibility of MHSUH systems and services nationwide, ensuring consistent care standards and equitable access to high-quality treatment. Uniform, performance-based standards allow healthcare organizations to foster consistently high-quality care and client safety. Conformity assessment plays a pivotal role in implementing these standards, evaluating organizations based on established criteria and promoting continuous improvement and accountability among service providers.

In response to the need for improved MHSUH systems and services, the Government of Canada partnered with SCC to launch the National MHSUH Standardization Collaborative. This initiative engaged diverse interested parties to develop a standardization Roadmap outlining current and desired goals. The Roadmap focuses on priority areas such as foundational issues, primary health services integration, children and youth, and support for individuals with complex needs including substance use health, aiming to bridge gaps in service delivery and improve outcomes from coast to coast to coast.

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[3] https://www150.statcan.gc.ca/n1/pub/11-627-m/11-627-m2023053-eng.htm

Recommendations from extensive engagement emphasize cultural sensitivity, equity, and accessibility gaps and considerations. The Collaborative focused on overcoming obstacles to accessing community-based mental health and substance use services, integrating these services into primary healthcare, and bolstering support for individuals with complex needs. Through various working groups and task forces, critical gaps were identified and addressed, leading to recommendations aimed at enhancing the accessibility, quality, and integration of substance use services with physical health. The Collaborative emphasized the importance of treating substance use issues in primary care settings and emergency rooms just like any other health condition. This involves ensuring appropriate referrals to specialized services and supports when needed.

Canada's efforts to standardize MHSUH services represent a significant step towards addressing pressing needs. With ongoing collaboration, the development of national standards and their implementation holds the promise of improving access to high-quality care and support for individuals across the country.

Tackling the Challenges and Identifying the Opportunities

WHAT WE HEARD FROM COLLABORATIVE MEMBERS

Working groups and task groups within the Collaborative frequently convened virtually to address central MHSUH issues. These gatherings were instrumental in identifying standards and facilitating the exploration of potential solutions. While some national standards, guidelines, and community-based documents could be tailored for a nationwide approach, others require centralized leadership to ensure inclusive and comprehensive access to MHSUH services across all provinces and territories. This approach is integral for addressing regional disparities and ensuring equitable care for all individuals.

Discussions underscored the importance of precise terminology, particularly in distinguishing between severity and seriousness while navigating the complexities of mental illness and mental health, and terminology used for substance use health (i.e. addictions, problematic substance use, etc.). Achieving consensus on definitions proved challenging yet key for effective communication.

Significant focus was placed on person-centred, trauma-informed care, and/or psychosocial rehabilitation approaches as the cornerstone of effective healthcare, necessitating systemic change. Standardized language and approaches were highlighted as critical across jurisdictions. The continuum of care, encompassing diverse services over time, was discussed, emphasizing the need for seamless integration and personalized approaches. Practical steps to address gaps, such as enhanced communication and proactive monitoring, were considered necessary within a stepped care approach, cautioning against compromising quality for cost-saving measures.

The vital role of families and caregivers[4] was prominently noted, highlighting their multifaceted contributions, often overlooked in healthcare systems. Recognizing the emotional, mental, and financial toll on well-being is paramount, as their own well-being significantly impacts the health outcomes of their loved ones, underlining the importance of balanced information sharing. However, concerns were raised regarding the challenges in maintaining boundaries between family/caregivers and healthcare professionals, potentially leading to conflicts of interest or breaches of confidentiality. Achieving a balance between the input of families/caregivers while upholding clients' autonomy and legal capacity is necessary yet complex. It was also noted that not all clients have a reliable support system, or a support system that is not always recognized (i.e. connection to animals or the land) exacerbating healthcare outcome disparities, particularly for marginalized populations.

Similarly, there was lack of consensus in how harm reduction was approached, with some participants noting that future iterations of the harm reduction key issue should prioritize a more nuanced approach, addressing complexities for individuals with complex needs. By acknowledging these challenges, standards

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[4] Please note that the term "family and caregivers" throughout this document broadly refers to individuals providing care without compensation, encompassing both familial ties and non-familial, informal circles of care, such as friends, as determined by the client. For some, support may also come from companion animals/pets that considered by many as family members and as a part of their support system (e.g., non-judgmental listener) and system of care (i.e., visit a therapy dog in their treatment facility).

can better support individuals navigating the balance between autonomy and well-being, especially considering the challenges posed by concurrent MHSUH conditions effecting capacity and the heightened risk of discrimination. Standards can provide clearer frameworks for healthcare professionals, fostering consistency and improving outcomes.

Establishing a shared understanding of individuals with complex needs was recognized as imperative before exploring key issues further. However, arriving at a consensus on the definition proved challenging due to differences in terminology and understanding among diverse members. This included individuals with lived expertise in MHSUH, as well as families/caregivers advocating for loved ones with complex needs. One notable difficulty was trying to capture all the different possible types of challenges that could be considered "complex". Members emphasized the importance of ensuring that everyone saw their experience reflected in the definitions. To address this challenge, the Collaborative agreed upon the following definition for the purposes of the Roadmap:

"Complex needs in the context of mental and substance use health, means the simultaneous presentation of one or more serious substance use and/or other mental disorders, which may include serious and persistent mental illness. Either of these could co-occur with significant challenges in various areas of life, such as physical health, social, employment, legal, housing, and overall well-being. These challenges collectively limit individuals' activities of daily living (ADL) and their level of functioning.

The level or degree of complexity can vary significantly across people who would be considered to have complex needs due to the unique number and mix of these challenging areas, the degree of acuity and chronicity at a given point in time, and also the strengths that the individual and family or other loved ones can draw upon. Individuals with complex needs often require services and supports from across various sectors and typically experience great difficulty receiving the required services due to fragmented systems and lack of coordination. People with complex needs may also require different services across their lifespan. Taking into account the challenges of availability and access for required services and supports, individuals experiencing co-occurring serious substance use and other mental disorders would be considered to have the most complex needs."

WHAT WE HEARD THROUGH BROADER CONSULTATIONS

In addition to the outcomes of the working groups and task groups, SCC conducted five separate consultations to broaden its engagement with people across Canada regarding features or principles for MHSUH. These consultations offered critical opportunities to involve the general public at key stages of the Roadmap's development, with the overarching objective of obtaining a national perspective on standardization and MHSUH.

Alongside a broad public consultation, an Indigenous-owned firm led an Indigenous consultation to address the limited representation of First Nations, Inuit, and Métis individuals in Canada within the Collaborative. This initiative reflects the Collaborative's commitment to decolonizing the healthcare system by recognizing land-based services and advocating for culturally informed healthcare.

In addition to these broad consultations, two unique issues were explored, reflecting consistent themes from the working groups: (1) anti-racism and (2) the unique context of substance use health.

The Anti-Racism report was initiated to address systemic racism and the unequal access to MHSUH care in Canada, which disproportionately affects Black people, Indigenous peoples, and People(s) of Colour (BIPOC). These disparities have been consistent topics in discussions among expert participants in the Collaborative. Standards have the potential to either perpetuate these inequities by reinforcing flawed systems or lay the groundwork for positive change. Thus, it is fundamental to ensure that national standards for MHSUH acknowledge and actively work to rectify these existing inequities. By delving deeply into this issue, we must aim to integrate anti-racist principles into Canada's standardization system, fostering a more inclusive and equitable healthcare system.

Regarding substance use health, while the working groups explored related issues, they did not fully address the interconnectedness of substance use health with mental health and overall well-being. It's necessary to recognize substance use health as a distinct yet interconnected topic without diminishing its significance. Substance use health doesn't always indicate poor mental health, but when co-occurring, it can delay mental health support, contributing to stigma and hindering access to care. Additionally, criminalization of some substances exacerbates stigma and discrimination, acting as a barrier to care. These

considerations underscore the importance of addressing substance use health within the Collaborative's work.

Finally, a consultation was conducted to assess the needs and opportunities for related conformity assessment and accreditation programs for MHSUH. The goal was to establish trust and credibility in standardization efforts around MHSUH among people living in Canada and interested parties, with insights from this consultation informing the broader context of the Roadmap.

Below provides the highlights of each of these consultations which are presented in full in the Annex.

Highlights from the Consultations

INDIGENOUS ENGAGEMENT

SCC retained The Firelight Group to support the design, development, administration, virtual logistics, and facilitation of initial Indigenous engagement across Canada. The objective was to garner Indigenous perspectives on MHSUH programs, services, and systems in Canada into considerations for the MHSUH Standardization Roadmap. This report provides background on issues related to First Nations, Inuit, and Métis MHSUH, and summarizes the results of engagements.

Focus groups were selected as the engagement method to generate rich conversations between First Nations, Inuit, and Métis communities from across the country, including from service providers, people with lived and living experience, and policy professionals. Youth, Elders, and 2SLGBTQIA+ (Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and additional sexual orientations and gender identities) were also critically important parts of these conversations. The purpose of the engagements was to understand the current state of MHSUH systems and services for First Nations, Inuit, and Métis peoples across Canada, identify and describe an ideal future vision of MHSUH systems and services serving Indigenous peoples, and seek perspectives on service standards.

Focus group discussions revealed significant challenges within the current MHSUH systems and services, such as the absence or inadequacy of mental health and substance use health services – including First Nations, Inuit, and Métis-specific services – the lack of a continuum of care, persistent anti-Indigenous racism and stigma, the hegemony of western-centric practices, language barriers, and the lack of attention to social determinants of health within mental health and substance use health systems and services.

Looking to the future, focus group participants envision MHSUH systems and services as primarily centred on distinctions-based and community-centred continuums of care that support individuals, families, and communities across the social determinants of health. These community-based systems will be connected to partners and jurisdictions through coordination and relationship building. Service providers and partner programs will be fully competent in cultural safety and deliver anti-racist, trauma-informed care.

Finally, focus groups considered the potential benefits and risks of service standards and shared several key considerations as the Collaborative began developing the Standardization Roadmap. Words and labels are powerful and bring with them history and context. Some participants shied away from the language of standards as a concept with colonial implications and suggested instead the notion of principles as establishing ways of knowing, being, and doing that is more reflective of Indigenous worldviews. This pointed to a need to be very purposeful and careful in developing both the Roadmap and ultimately standards. Further, standards should be distinctions-based and flexible enough to account for cultural, geographic, and community differences.

The focus groups also highlighted the need for standards to be just one element of a larger system and societal transformation that must be built in relationship with Indigenous peoples and reflective of Indigenous self-determination. In terms of themes that emerged as important considerations in developing Indigenous-specific standards, participants advocated for trauma-informed and culturally safe care, holistic and integrated care, integration of Indigenous strengths-based healing, reciprocal relationships, Indigenous staff recruitment and retention, and equity.

The Firelight Group's full consultation report can be found in Annex C of this document.

PUBLIC CONSULTATION: SETTING THE CONTEXT FOR MENTAL HEALTH AND SUBSTANCE USE HEALTH IN CANADA

Hill and Knowlton (H&K) partnered with SCC to undertake a national consultation process to learn about the challenges and opportunities surrounding MHSUH standardization in Canada. This consultation process focused on understanding MHSUH care at the service, program, policy and system levels based on the diverse perspectives and experiences of people that access and receive care. It consisted of three phases:

Phase 0: Learning about the MHSUH Landscape – November 2023 to September 2024: H&K completed secondary background research to better understand prevalent MHSUH trends and the disproportionate impacts that they have on equity-deserving groups. To complement the research process, the consultation team engaged in learning and capacity building activities to better equip them to convene inclusive, supportive conversations on MHSUH.

Phase 1: Learning about MHSUH Services – October 2023 to January 2024: As a foundation for the consultation process, H&K learned exclusively from people with living and lived experience by inviting their perspectives and experiences on MHSUH services in focus groups and one-on-one discussions. People with living and lived expertise were invited to share reflections and insights on the current state of MHSUH services, their desired future state of services, and the steps and actions required to move from the current state to the future state.

Phase 2: Learning about MHSUH Programs [Services] and Policies – February 2024: Grounded in the learnings gathered from the first phase, H&K hosted a national convening event for policy makers, service providers, non-governmental organizations, and pan-Canadian health organizations, including people with living and lived experience serving in these capacities. These experts were invited to reflect on what was learned in the first phase on MHSUH services and use those learnings to take stock of the current state of MHSUH programs and policies, imagine the future state of programs and policies, and discuss the role of standardization in implementing the recommendations raised by people with living and lived experience.

The conversations convened in the consultation process started by asking participants about their perspectives and experiences of the current state of MHSUH care. Participants expressed that the MHSUH system is broken, that it is hard to navigate and that its various components do not work well together. They discussed the unresponsiveness of the system and how there are structures within it that are contradictory or that create unnecessary barriers to accessing care. Participants also highlighted the relationships between the MHSUH system and the medical system and how these two systems can sometimes operate in antithetical ways. A large part of understanding this disconnect is inspecting stigma and the continued lack of awareness and education on MHSUH challenges in medical settings and among the general public. Although many conversations focused on important challenges, several examples of positive work being done in communities were spotlighted as case studies to celebrate and build from.

After taking stock of the current state of MHSUH care, participants were invited to imagine what the future state of care should look and feel like. Participants emphasized the necessity of taking evidence-based approaches, rooted in the learnings and best practices that already exist and that people across the country have already been championing. Participants discussed the need to create a MHSUH system that is trauma-informed and person-centred and considered the opportunity that building a continuity of care provides in centring and practicing these philosophies throughout care journeys including user evaluation/feedback to inform and improve service. There were several conversations that focused on reducing systematic barriers that prevent people from accessing care, such as cost, rigid criteria and a lack of coordination, and working to ensure that MHSUH care is treated as a full and equal part of our universal health care system systems and other systems that ensure people receive the services and supports they need. Participants highlighted the important role that standards could play in implementing these principles and practices and helping to provide integrated, responsive, and high-quality care.

To bring everything together, participants explored the steps and actions that need to be taken for the MHSUH systems and services to move from the current state to the future state. They started by expressing that, while they understand that implementing standards is a long-term endeavour, there are urgent steps that should be taken to prevent people from dying and experiencing further harm. They shared other steps that require either new policies to be formulated or existing policies to be reviewed and potentially amended. They outlined concrete actions that would bear directly on care access and quality, including creating a central access point within one's community, providing more flexible service delivery, increasing or reallocating funding for services, and developing training and education curricula across different sectors of society. In undertaking all of these steps and actions, participants emphasized the central role that people with living and lived experience must play in designing, implementing and evaluating changes across services, policy and system levels.

Hill & Knowlton's full consultation report can be found in Annex D of this document.

ANTI-RACISM AND MENTAL HEALTH AND SUBSTANCE USE HEALTH

In 2019, SCC published a report on gender and standardization, which emphasized that standards are not neutral in their impact—they are shaped by those involved in their development. The report highlighted a concerning finding: standards do not offer the same level of protection to women as they do to men, partly due to the underrepresentation of women in standards development and a lack of gender expertise in the process. To address this disparity, SCC devised a Gender and Standardization Strategy aimed at increasing gender representation, integrating gender expertise into standardization, and conducting research to identify and rectify gender inequities. As a result, gender considerations have gained greater prominence within SCC, and national leadership is also helping bring those considerations to international standards development.

Building on the success of SCC's efforts in promoting gender-responsive standards, a similar approach could be expanded to address issues of race and anti-racism, thereby fostering a more representative and equitable standardization system. Initially focusing on MHSUH standards, this approach could eventually encompass a broader examination of systemic racism throughout the entire system. While the Collaborative acknowledges the many identities that can lead to inequities when accessing and experiencing MHSUH services, the work of this group focused on race.

To facilitate this expansion, SCC engaged The Firelight Group to conduct several sessions/interviews with BIPOC Collaborative members aimed at drafting a report for the Roadmap that explores the unique challenges faced by racialized communities, particularly BIPOC, who encounter disproportionate barriers to accessing quality care due to systemic racism and discrimination. By exploring the intersection of racism and MHSUH, the report aims to provide a comprehensive understanding of the complex social determinants influencing outcomes in these areas. It emphasizes the adoption of anti-racist approaches in healthcare delivery to ensure equitable access and support for all individuals, irrespective of their background or ethnicity.

Racism permeates various levels of MHSUH systems and services, from interpersonal biases to institutionalized discrimination. BIPOC individuals often face barriers to care, encounter culturally insensitive services, and are disproportionately affected by overcriminalization. These systemic failures exacerbate MHSUH challenges, leading to poorer health outcomes and perpetuating cycles of marginalization.

To effectively tackle racism within MHSUH systems and services, a multifaceted approach is needed:

- Legislative Reforms: Prioritizing equitable access to care through legislative measures that recognize and address systemic barriers faced by BIPOC communities.
- Culturally Humility and Safety Frameworks: Adopting cultural humility and safety frameworks for service provision that centre the experiences and needs of diverse communities and engenders both program and system transformation.
- Community-Specific Programs: Developing tailored programs rooted in strengths-based approaches, acknowledging, and leveraging the resilience and assets within BIPOC communities.
- Monitoring and Evaluation: Implementing robust mechanisms for monitoring and evaluating progress, developed in collaboration with communities, to identify areas for improvement and hold institutions accountable.

By centring anti-racism and equity in the development of standards, the Collaborative aims to dismantle systemic racism within MHSUH systems and services and pave the way towards greater equity and inclusivity. This involves gathering insights from BIPOC individuals, identifying effective practices for preventing and responding to racism, and ensuring that standards actively contribute to dismantling systemic inequities. Continued efforts to amplify the voices of BIPOC communities, advocate for legislative reforms, and foster partnerships rooted in equity and anti-racism are integral for creating a healthcare system that truly serves and uplifts every individual, regardless of race or ethnicity.

The Firelight Group's full report on anti-racism can be found in Annex E of this document.

THE UNIQUE CONTEXT OF SUBSTANCE USE HEALTH

SCC partnered with the Canadian Centre on Substance Use and Addiction (CCSA) to provide a report on the unique context of substance use health.

When considering aspects of health, it is generally understood that there is a spectrum from well-being to illness on which an individual may find themselves. Their position on this spectrum may change over time and across situations, or it may depend on the aspect of health in consideration. For example, a person's physical health may be considered “good” one day and change abruptly the next day following a diagnosis of a serious illness. Another example is an individual who is considered to be doing “well” overall, but they have a nagging shoulder injury that reappears when they play tennis. This understanding of health is fluid and flexible. It acknowledges the nuances of different life experiences and allows for every individual to hold their own understanding and perception about their physical health.

The use of alcohol and other drugs have not been considered in the same way historically. Knowing the importance of language for driving perceptions and stigma, the Community Addictions Peer Support Association (CAPSA) and other key experts have championed the use of the term substance use health. Moving the conversation

from focusing only on use and related problems, a substance use health framework acknowledges a spectrum that may include no use at all, beneficial use, use that poses acute or chronic risks, and use that can be categorized as a substance use disorder. None of the components of the spectrum are mutually exclusive. Conceptualizing substance use health in the same manner as we do physical and mental health allows for all people living in Canada to see themselves on this spectrum. This can help address the othering and stigma experienced by people who have been labelled with "addiction." It will also allow for supports to be provided to individuals at any point on the spectrum, facilitating recognition of concerns and intervention before an individual experience's severe levels of harm.

A substance use health framing provides an opportunity for inclusive education, health promotion and service provision, and it will allow for substance use health care to be integrated into services and supports more broadly. Yet, there are components of substance use health that are distinct and which require consideration when developing policy and program responses.

The Canadian Centre on Substance Use and Addiction's full report on substance use health can be found in Annex F of this document.

THE ROLE OF CONFORMITY ASSESSMENT

SCC partnered with Health Standards Organization (HSO) to evaluate the needs and opportunities for related conformity assessment programs for MHSUH.

In the standardization field, accreditation refers formal, third-party recognition by an independent body (generally known as an accreditation body, such as the Standards Council of Canada) that an organization is competent to perform specific tasks – the work for which they are accredited. It can be voluntary or mandated by the government. It is a continuous quality improvement process to demonstrate that internationally and/or nationally prescribed standards have been met. Distinctly, conformity assessment is the practice of determining whether a product, service, or system meets the requirements of a particular standard.

Throughout this report, the term "accreditation" is used in a manner customary in the healthcare sector; it can be interpreted to mean conformity assessment plus continuous quality improvement.

As an integral part of this initiative, comprehensive research, evidence review, and extensive engagement—including interviews, surveys, and discussions—were conducted with people with lived and living experience and expertise, Indigenous experts, health and social service providers, government, not-for-profit organizations, researchers, academics, and accreditation bodies. The objective of this engagement was to identify perceived strengths, limitations, and potential improvements in conformity assessment processes.

Throughout these engagements, there was a clear sentiment that conformity assessment can play a key role in enhancing MHSUH systems and services. Respondents emphasized conformity assessment's role in enabling quality care, driving continuous improvement, bolstering organizational reputation, enhancing safety, promoting standardization, and serving as a benchmark for best practices. However, the conversations also revealed notable perceived limitations of conformity assessment, including inadequate representation from communities and diverse individuals, high resource and financial costs, overly complex and resource-intensive programs, insufficient oversight leading to superficial implementation, cultural competency gaps, and a lack of emphasis on health outcomes.

The recommendations outlined in this report aim to address the identified limitations and include:

1. Importance of Client-Centric Collaboration
2. Maintaining Timely and Relevant Standards and Accreditation Programs
3. Cultural Competency and Sensitivity of Standards and Accreditation Programs
4. Optimized Accreditation Process
5. Increase Knowledge and Understanding of Standards and Accreditation
6. Accreditation as a Lever for Building a Culture of Quality and Safety
7. Focus on Integrated Care in Standards and Accreditation Programs
8. Reducing Barriers to Implementing Accreditation Programs

These recommendations can contribute to transforming the MHSUH sector, addressing challenges, and fostering a more person-centred, inclusive, and responsive system.

The full HSO report can be found in Annex G of this document.

Addressing stigma, discrimination, systemic inequities, and service provision gaps in MHSUH care in Canada requires a comprehensive approach. By integrating diverse perspectives, prioritizing inclusivity and accountability through standardization, interested parties can collaboratively work towards creating a more equitable and effective healthcare system for all people living in Canada. Through collective action and a commitment to continuous improvement, the goal of providing high-quality MHSUH care for everyone can be achieved.

Issues and Recommendations

Identification of Key Issues

In 2022, the Collaborative began identifying priority areas for the Roadmap, eventually narrowing down to twenty-four (24) issues due to the vast scope of MHSUH issues and complexities. Recognizing the significance of standards in these areas, especially given the decentralized nature of governance across provinces and territories, they were seen as pivotal tools adaptable across jurisdictions. Continued engagement with governments, policymakers, healthcare professionals, and individuals with lived and living experience is key for fostering public trust in Canada's MHSUH care system, forming the bedrock of our framework. This trust is bolstered not only by developing new standards but also by supporting public policies and legislation. Proper standardization ensures access to the highest quality and safest products, systems, and services for people living in Canada.

Working groups and their respective task groups convened online to outline and define the selected issues, with SCC secretariats aiding in inventorying existing standards, conducting gap analyses, and drafting the Roadmap. Adopting a participatory research methodology, all working group members served as subject matter experts, contributing their perspectives to the knowledge-production process (i.e., Roadmap development). Each working group and secretariat followed these steps to map the landscape of published standards relevant to each issue.

Diagram 1: Development of Standardization Landscape

In total, approximately 1387 standards and other reference documents were identified across the twenty-four (24) issues (a detailed selection methodology can be found in Annex J). Based on a preliminary list of standards and other public documents, and the discussions of the working groups and task groups, the secretariats scoped the gaps that existed in current national standards for each respective key issue. A "gap" was defined as the absence of a published standard, specification, or other type of document covering the issue in question.

The Roadmap is supplemented by the MHSUH Landscape, a table of standards directly or indirectly related to the issues described in the Roadmap, available in Annex K.

As previously mentioned, the Roadmap addresses priority areas guided through federal, provincial, and territorial consensus in 2017. These priority areas are complex and dynamic, undergoing continual evolution and adaptation, involving multiple parties. It was acknowledged from the outset that MHSUH could be approached from various perspectives and models.

To address this, activities were structured under four broad domains, further divided into four working groups: (1) Foundation and Integration, (2) Primary Health Services Integration, (3) Children and Youth, and (4) People with Complex Needs. Within these domains, broad topical areas relevant to standards and conformity assessment programs for MHSUH were identified.

Recommendations

A summary of recommendations related to the twenty-four (24) examined issues is provided. These recommendations aim to guide future discussions on closing identified gaps and demonstrate how standardization can enhance confidence and trust by offering clear guidelines, consistent practices, safe products, and reliable protocols. These summaries are not exhaustive and should be read alongside Annex A, which contains more comprehensive summaries of Working Group and Task Group discussions of the key issues. When developing action plans to implement each recommendation, it is advisable to review each issue along with the consultation reports, and the standardization landscape provided in Annex K. Additionally, a condensed version of the landscape, featuring a list of directly relevant standards and other normative documents, is available in Annex B.

Working Group 1: Foundation and Integration

Issue 1 —
Stigma Free and Consensus-based Terminology and Language

Scope: Establishing stigma-free and consensus-based terminology for MHSUH discussions and services is necessary to combat stigmatization, improve access to care, and remove barriers faced by marginalized communities, ensuring inclusivity and accurate representation in healthcare.

Recommendation: Review existing standards and developed guidelines to build, and evaluate context-specific, non-stigmatizing, person-centred, inclusive, trauma-informed, and consensus-based terminologies, and language.

Issue 2 —
Different Types of Evidence and Experiences

Scope: Addressing biases and systemic discrimination in healthcare requires unbiased analysis and conclusions produced using an equity and inclusion lens, acknowledging the influence of systemic racism, colonialism, and biases in data collection and interpretation.

Recommendation: Using a diverse and inclusive approach, develop standards that define and establish what evidence entails, how experience can inform evidence and be recognized in a way that leaves no one behind in the provision of MHSUH care.

Issue 3 —
Accountability and Evaluation Mechanisms

Scope: Accountability and evaluation mechanisms ensure responsibility, oversight, and continuous improvement in MHSUH services, fostering transparency, equitable care delivery, and addressing cultural considerations.

Recommendation: Develop standards for inclusive accountability and evaluation mechanisms to achieve high-quality mental health, substance use health, and mental illness care.

Issue 4 —
Human Rights and Substantive Health Equity

Scope: Integrating human rights, equity, and accountability mechanisms into MHSUH services is essential for creating an inclusive healthcare system that addresses disparities and respects individual autonomy and cultural diversity.

Recommendation: Develop standards that provide guidance on how to implement health equity for everyone and place people's right to health at the centre the provision of mental health and substance use health services, care, and treatment.

Issue 5 –
Harm Reduction Principles and Approaches

Scope: The integration of harm reduction principles into MHSUH services must align with principles of equity, access, autonomy, and dignity, emphasizing a person-centred approach while acknowledging historical and intergenerational trauma.

Recommendation: Develop standards that provide specific guidance for the implementation of harm reduction principles and approaches in mental health, substance use health and mental illness care, while recognizing the need to regularly revisit these guidelines for an effective and evolving health care system dedicated to harm reduction for all, across Canada.

Issue 6 —
First Nations, Inuit, and Métis Knowledge Systems and Inherent and Treaty Rights

Scope: Integrating Indigenous knowledge systems into MHSUH services is essential for upholding the human rights and self-determination of First Nations, Inuit and Métis Nations and ensuring equitable access to care within a decolonizing framework.

Recommendation: Develop standards for the delivery of MHSUH services specific to the needs of First Nations, Inuit and Métis, and adapted to the distinct needs of their communities as distinct rights holders.

Issue 7 —
Privacy and Confidentiality Related to Mental Health and Substance Use Health

Scope: The MHSUH sector play a role in addressing sensitive privacy and confidentiality issues, ensuring equitable access to care for vulnerable populations.

Recommendation: Develop standards to ensure shared responsibility between the client and healthcare professionals regarding access to and control of private and personal information and collection of collateral background facts. Develop jurisdiction-specific standards about the involvement of families while considering cultural difference and communities' features.

Issue 8 —
Quality of Health Services Achievable by Effectively Addressing the Social Determinants of Health

Scope: MHSUH services must address social determinants of health to achieve equitable access to quality care and reduce health inequalities across sectors.

Recommendation: Develop standards for effectively managing the social determinants of health to achieve quality health for all. These standards should establish a correlation between the social determinants of health and the provision of quality health services, and not be limited to the MHSUH sector.

Issue 9 —
Workforce Health, Trainings and Competencies

Scope: Addressing gaps related to workforce health, continuous training, and competency development in the MHSUH sector.

Recommendation: Develop standards to enhance the health, training, and competencies of the MHSUH workforce.

Issue 10 —
Continuity and Transition of Care

Scope: Improving continuity and transitions of care in MHSUH by implementing harm-reducing and person-centred standards as well as coordinated access to care in Canada.[5]

Recommendation: Complete work on continuity and transition of care based on the existing standards. These additional standards can focus on the development of consensus-based definitions of concepts that may have different interpretation from a client's point of to that of a physician such as: coordination, access, integration etc.

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[5] Regarding **Continuity and transitions in Care**, there was a lot of discussion pertaining to the treatment system taking into consideration the whole person and the goals of the person. This identification of the person's comprehensive needs and goals would help in establishing what is needed by the person in the service and beyond and what the clinical team needs to do to ensure comprehensive care, continuity and effective transitions.

Working Group 2: Primary Health Services Integration

Issue 11 — Timely Access to MHSUH Care

Scope: Timely and coordinated access to MHSUH care is fundamental, employing supportive, person-centred, and trauma-informed approaches to reduce barriers and improve outcomes, particularly for underserved populations.

Recommendation: That guidance be developed to help improve access to MHSUH services, particularly through better connections with the primary health services system.

Issue 12 — Continuum of Care

Scope: Integration across the continuum of MHSUH care systems is imperative for seamless care, considering individual autonomy, circumstances, and potential co-occurrence of issues, while ensuring equitable funding mechanisms.

Recommendation: That standardized guidance be developed to outline how best to integrate the continuum of care—encompassing education, prevention, early intervention, public health, primary care, acute care, treatment, aftercare, and community support and social determinants of health—to improve equity and access to MHSUH care for people in Canada.

Issue 13 - Quality Assurance for Digital MHSUH Applications

Scope: Quality assurance for digital MHSUH applications (apps) is needed to ensure adherence to quality standards, data privacy, and evidence-based, trauma-informed advice, potentially through a certification scheme for reliable apps.

Recommendation: That the feasibility of establishing a conformity assessment scheme for digital MHSUH apps be examined and, if appropriate, that the scheme be established.

Issue 14 — Behavioural and Technical Competencies and Workforce Development for Those Involved in MHSUH Care for People in Canada

Scope: Standardizing competencies across the MHSUH workforce is imperative for equitable, trauma-informed care, emphasizing the removal of stigma and bias, and providing support for families and caregivers.[6]

Recommendation: That a series of standardized guidance be developed prescribing behavioural and technical competencies for workforces involved in safeguarding the MHSUH of Canadians.

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[6] It was also noted that it was important to ensure healthcare professionals within scope of practice are being supported in utilizing their full skill set and keeping current and relevant and professional boundaries are being recognized.

Issue 15 —
Mobile Crisis Response/Mobile Crisis Care

Scope: Mobile crisis response units can provide urgent care, stabilization, and transportation to appropriate facilities, potentially relieving strain on emergency services, with national guidance incorporating best practices and coordination for optimal care provision.

Recommendation: That national guidance be developed on how to establish, manage, and coordinate mobile crisis care units for individuals experiencing MHSUH crisis.

Working Group 3: Children and Youth

Issue 16 —
Youth-Partnered Care

Scope: Young people have distinct MHSUH needs, necessitating care providers to engage them meaningfully, consider their unique circumstances, prioritize prevention and positive coping strategies, and deliver evidence-informed interventions in a youth-partnered model without stigma or judgment.

Recommendation: That a normative document be developed that will (A) outline what young people can expect from care providers when seeking MHSUH interventions, and (B) provide guidance to care providers on how to partner with and meaningfully engage young people in their health care decisions.

Issue 17 —
Promoting Access to Equitable and Culturally- and Identity-Affirming Youth-Partnered Care

Scope: Young people require MHSUH care that is equitable, culturally affirming, trauma-informed, and youth-partnered, focusing on fostering agency, reducing wait times, addressing funding disparities, and respecting the needs of those involved in the corrections system.

Recommendation: That guidance be developed to establish and promote access to equitable and culturally- and identity-affirming youth-partnered care.

Issue 18 —
Systematic Screening Processes and Tools for Youth

Scope: Effective screening processes and tools for children and youth prioritize a partnership with the individual, counter stigma, provide early intervention, ensure timely access to care, and support smooth transitions between providers while respecting data privacy and sovereignty.

Recommendation: That guidance be developed to outline how to develop systematic screening processes and tools that prioritize youth agency and help children and youth access the mental health and/or substance use health care they need in a timely manner.

Issue 19 —
Communication and Collaboration Across the Continuum of Care for Children and Youth

Scope: Effective communication and collaboration across interested parties, including families, schools, and healthcare providers, is needed to support the MHSUH of young people, ensuring early intervention, personalized care, and continuity throughout transitions in care.

Recommendation: That guidance be developed to facilitate communication and collaboration between young people, families/chosen families, community organizations, and the continuum of care in improving or preserving the MHSUH of young people.

Issue 20 —
Substance Use Health Care for Young People

Scope: Young people seeking substance use health care require developmentally appropriate support focusing on education, early intervention, evidence-based harm reduction, and addressing co-occurring MHSUH issues, ensuring access to care regardless of abstinence-based approaches or involvement in the corrections or child welfare systems.

Recommendation: That guidance be developed to outline effective strategies to support the substance use health of young people through education, early intervention, and evidence-based harm reduction.

Issue 21 —
Support for Caregivers Who Support Young People

Scope: Family, chosen family, and caregivers play a role in supporting young people with MHSUH challenges, requiring access to information, resources, and support systems that are culturally relevant and inclusive of diverse identities.

Recommendation: That tools be developed to provide necessary resources and support for caring adults (family, chosen family, other meaningful adults) who support the health and wellbeing of young people.

Working Group 4: People with Complex Needs

Issue 22 —
Person-Centred Healthcare and Co-creation of Care

Scope: Person-centred, trauma-informed care is vital for individuals with complex needs. It prioritizes their unique goals and preferences while addressing physical, mental, and substance use health, as well as social well-being, while safeguarding client rights and autonomy. To establish a coordinated care approach, systemic changes such as pan-Canadian standards and policies co-developed with individuals with lived/living expertise, as well as families and caregivers, are required.

Recommendation: To effectively implement person-centred care, it is imperative to implement systemic changes, including the development of standards, guidance, and policies collaboratively developed with individuals with lived/living expertise, as well as families and caregivers. This collaborative approach will foster a person-centred culture within clinical settings and provide essential support to families and caregivers as they navigate the complexities of care.

Issue 23 —
Valuing the Role of Families/Caregivers in Supporting People with Complex Needs, and Acknowledging their Own Needs for Services/Supports

Scope: Families and caregivers of individuals with complex needs play a crucial role in navigating the healthcare system and providing critical support. However, they often face challenges such as suboptimal treatment and strained relationships due to operating independently of the health system. It is important to recognize the emotional, mental, and financial toll of their role and include them as key partners in mental health and substance use healthcare.

Recommendation: The development of robust standards is imperative to bridge the gap identified in "Valuing the Role of Families/Caregivers in Supporting People with Complex Needs." To address the evolving needs of both caregivers and people with complex needs across the lifespan, it is recommended to establish national standards that emphasize the significance of families/caregivers. These standards should articulate how healthcare providers can effectively engage caregivers and support networks in care planning, decision-making, and treatment processes while upholding clients' autonomy.

To enhance these standards, consider several key aspects. Firstly, given the difficulties families face due to variations in how the Mental Health Act is interpreted, it is recommended to establish a formal process for reviewing provincial acts with a clear vision and the aim of achieving standardization. While there are similarities among the 13 jurisdictions, nuanced differences in each province's laws make it challenging for parents to navigate healthcare systems. Collaborative efforts and uniformity in legal and regulatory requirements will assist parents in navigating healthcare processes effectively.

Secondly, a key aspect of these standards should involve recognizing the changing requirements of caregivers and people with complex needs at various life stages. This may require the creation of adaptable support models that can be customized to address specific circumstances and challenges encountered by both caregivers and those under their care.

Thirdly, to ensure successful implementation, it is advisable to introduce targeted training programs for healthcare professionals. These programs can enhance professionals' comprehension of the pivotal role of caregiver involvement and offer practical strategies to effectively engage support networks. This initiative can foster a culture of collaboration and partnership between healthcare providers, support networks, and caregivers, ultimately contributing to more holistic and effective care. Additionally, training programs should include guidance on navigating privacy and confidentiality laws to ensure that they do not hinder care.

Lastly, it is essential to integrate cultural competency training and considerations into the standards. Acknowledging the diverse backgrounds of caregivers and people with complex needs, the standards should advocate for tailored approaches that respect cultural sensitivities and promote inclusive care practices.

To conclude, the establishment of comprehensive national standards that prioritize the role of families and caregivers in supporting individuals with complex needs is a vital step towards more inclusive, person-centred, and effective MHSUH. By addressing the challenges related to legislative variations, recognizing the evolving needs of caregivers, providing targeted training for healthcare professionals, and promoting cultural competency, these standards can significantly enhance the quality of care delivered across the country. Through collaboration and a shared commitment to the well-being of individuals and their support networks, we can build a more supportive and responsive healthcare system for all Canadians.

Issue 24 — Continuum of Care for Complex Needs

Scope: The "continuum of care" encompasses various healthcare services provided to individuals over time, tailored to their needs and considering social determinants of health. Gaps currently hinder seamless care, particularly for those with complex needs. A comprehensive assessment, co-led by individuals with lived/living expertise and families/caregivers, in collaboration with healthcare professionals is necessary to identify specific gaps and prioritize perspectives and improve care outcomes.

Recommendation: Conduct a thorough assessment to identify specific gaps along the continuum of care, including barriers to access, fragmentation of services, and disparities in care delivery. This assessment should be co-led by individuals with lived and living expertise and families/caregivers, in collaboration with healthcare professionals. By empowering individuals with lived and living expertise and families/caregivers to take on leadership roles in the assessment process, their perspectives, needs, and preferences can be prioritized and centred. This collaborative approach ensures that the assessment is conducted with a deep understanding of the challenges faced by those directly impacted, leading to more meaningful insights and effective solutions.

Next Steps

This Roadmap is a first iteration to address the pressing challenges in Canada's MHSUH care system. Guided by recent government actions and collaborative endeavors, it provides a path toward consistently and comprehensively addressing the multifaceted aspects of MHSUH care improvement, with a focus on accessibility, quality, and equity.

Through engagement with working groups, task groups, and participants, the Roadmap highlights critical areas such as foundational integration, primary health service alignment, youth MHSUH, and support for individuals with complex needs. It stresses the importance of collective action, fostering trust, and sustained engagement with policymakers to translate recommendations into tangible enhancements across Canada's mental health and substance use healthcare landscape.

However, the issues addressed here only scratch the surface of the broader challenges within our healthcare system. Participants in the Collaborative expressed a desire to delve deeper into topics such as involuntary treatment, the role of peer support workers, evidence based and informed care, the need for mental health program/services for those employed or employable, but are struggling or on Long Term Disability, as well as explore avenues for innovation to name just a few.

Diverse viewpoints were expressed regarding the involvement of families and caregivers in discussions around involuntary treatment. While some recognized the support role families can play for individuals with mental illness who may struggle to advocate for themselves, concerns were raised about current guidelines and the potential for human rights violations and insufficient

directives for early treatment access for those with severe mental illness.

To address these issues, it was emphasized that the meaningful involvement of individuals with lived and living experience throughout the entire healthcare system is integral to ensure the delivery of appropriate, effective, and high-quality MHSUH care. This includes user evaluations for continual input to inform and steer services.

The flexibility of the standardization system in setting minimum requirements is an invitation to action to address challenges. Determining where standardization can add value versus where policy or other factors are necessary will be instrumental. Regular revisiting of this work is suggested to keep the Roadmap updated and oversee its implementation.

The next steps involve translating Roadmap recommendations into action to address identified challenges and opportunities in MHSUH care, fostering trust and collaboration among various stakeholders.

Implementation of the twenty-four (24) recommendations will require leadership and support for the adoption or development of standards, conformity assessment activities, detailed analysis, and action plans. Indigenous engagement recommendations should be integral to the implementation plan, including outreach and tying findings to working group issues. Ensuring resources are available to Indigenous organizations to enable participation in a meaningful way is vital.

Continued commitment from a Steering Committee and Collaborative, ongoing funding, and short-term outcomes such as oversight and communication are needed for the Roadmap's success. Action plans for the recommendations would position Canada to implement stigma-free language, incorporating diverse evidence, accountability mechanisms, prioritization of human rights, integration of Indigenous knowledge, privacy enhancement, workforce improvement, care continuity, timely access, and systematic screening processes.

This is expected to lead to the development of new national standards and conformity assessment programs to promote and protect MHSUH interests and priorities through quality, trust, and ethics-based standardization solutions.

Next steps are dependent on new funding. With funding, a second version of the Roadmap would address new issues and provide updates on implementation progress.

Annex A

Gap Analysis

This roadmap section presents an overview of MHSUH participant's views on key issues related within the MHSUH domain and the role standardization in addressing those issues. It encompasses descriptions and scope of issues, and recommendations on the need for additional R&D and/or standards and specifications, and the organization(s) that potentially could perform the work. It is divided into several sections corresponding to the MHSUH working groups: Foundations and Integration; Primary Health Services Integration; Children and Youth; and People with Complex Needs. It is important to note that even though each working group followed a similar methodology, their analysis may have taken slightly different paths due to complexity, often resulting in differing perspectives and conclusions. Therefore, it is noted that the recommendations on organization(s) that could potentially perform work should not be viewed as conclusive or in any order of preference or authority.

Working Group 1: Foundation and Integration

Issue 1 - Stigma Free and Consensus-based Terminology and Language

To discuss MHSUH, there is a need to establish stigma-free and agreed-upon terminology for all concerned parties. Stigmatization often reflects mindsets, misunderstanding, and social constructs that result from and lead to the use of hurtful words. Many people with lived and living expertise testify to their reluctance and avoidance of available health care services, treatments, and professionals because of either experienced or reported stigmatization. Stigmatization can also mean that people are not comfortable using words that refer to a wide range of existing mental health conditions; when people avoid using certain terms such as "mental illness", these conditions are less acknowledged and recognized, and services are less accessible because few people discuss the issue. Stigmatizing language can lead to shaming, labelling, misplaced blame, inadequate health care, providers avoidance, and even premature death. Accepted, context-specific, non-stigmatizing, person-centred and group-centred diagnostic terminology can help remove stigma from discussions of MHSUH.

A single word can have several interpretations, sometimes even contradictory, depending on the speaker, context, and tone. As such, key terms need to be defined in a manner that embraces the plurality of people and/or parties that are both concerned and impacted. Public and consensus-based consultations are vital when developing standards on MHSUH terminologies. A regular and ongoing review of terminologies is important and should seek input from diverse peoples, especially those with lived and living expertise.

Standards for terminologies need to be non-prescriptive, in the sense that it does not diminish access for unique populations (such as First Nations, Inuit, and Métis populations, newcomers etc.) and ensure greater communication. The terminologies should not be exclusionary against certain cultures, identities, identity-first language, groups of minority populations, equity-denied people, equity-deserving people, equity-seeking people, 2SLGBTQIA+ people, Black, Indigenous and People of Colour, etc. Considering this aspect would help address historical trauma, systemic barriers, cultural appropriation, discrimination, exclusion, marginalization, indigenous-specific racism, racism and create room for emerging terminologies. Indigenous specific resources/authored materials can assist in decolonizing the Euro-centric focused "standards/best practices" for MHSUH terminologies. With regards to newcomers in Canada, considering international standards would also be helpful to avoid stigmatization and embrace diversity.

To implement standards on terminology and language in the most efficient and impactful manner, it is crucial to define the primary audience for these guidelines, best practices, or standards. It would ensure that nothing or no one is off the table. It is vital to identify what level of systems of care is targeted, which standards apply to the federal, provincial, territorial government, as well as the municipalities of Canada; what service programs at the front line are considered, and what category of actors are primarily concerned.

Gap: Stigma Free and Consensus-based Terminology and Language. Stigma around MHSUH means that those who need care are less likely to seek it. To help remove stigma from these conversations, standardized guidance is needed to establish stigma-free, consensus-based terminology and language. This guidance should also cover areas requiring further development in the MHSUH sector, such as culture-specific terminologies for unique populations, including Indigenous Nations and newcomers; people with lived and living expertise regular review of existing and current terms, identification of target audiences for each set of standards, among others.

Recommendation: Review existing standards and developed guidelines to build, and evaluate context-specific, non-stigmatizing, person-centred, inclusive, trauma-informed, and consensus-based terminologies, and language.

Organization(s): Mental Health Commission of Canada, Community Addictions Peer Support Association, Canadian Institutes of Health Research, Canadian Institute for Health Information, Health Standards Organization, Centre for Addictions and Mental Health, Inuit Tapiriit Kanatami, First Nations Health Authority, National Collaborating Centre for Indigenous Health, Black Health Alliance, Canadian Mental Health Association, Canadian Centre on Substance use and Addiction.

Issue 2 - Different Types of Evidence and Experiences

Attitudes, beliefs, and actions in the healthcare setting can be influenced by systemic racism, colonialism, stereotypes, misinformation, inequity among other factors. Analysis and conclusions resulting from the data and information should be unbiased and produced using an equity and inclusion lens.

Knowledge can be gained or informed by different channels, including (but not limited to) academic research, lived and living expertise, professional experience, and culture. However, the tools, processes, and methods used in health care are often western-based, Eurocentric, biased and thus exclusionary. Special communities that are traditionally marginalized should own and interpret their own data and knowledge instead of having it done on their behalf. By addressing biases and systemic discrimination in the collection and interpretation of data, person-centred and human rights-based standards will build trust and marginalized, racialized, and underserved populations will feel accurately represented. Using a diverse and inclusive approach through respectful public dialogues would bring to light all these types of knowledge, evidence, and experience.

It is imperative to define what is meant by the term “evidence”, when and how such evidence or experience can be recognized. In this era of artificial intelligence and social networking, standards must also accommodate the emergence of new platforms that publish and collect information. This means defining how information is captured and how data is validated, as sometimes innovation is not yet evidence based but evidence informed. Because evidence is not one size fits all, it is important to define how the plurality and context of MHSUH data is understood and interpreted, how to reconcile the expectations of underrepresented groups, how knowledge is graded and outcomes measured, including user evaluations and feedback.

Mandatory reporting with diverse knowledge, asset-based data, and outcome data at all levels would help in moving away from a deficit model of data collection. In this regard, a governing body or structure can filter out all types of evidence and experience, assess and certify what is working or not, under what context and stages of peoples' lifespan. Evidence needs to be inclusive, and not only based on Western or traditional ways of collecting data. Shifting to outcome-based monitoring and reporting would also help. However, it is necessary to recognize the importance of evidence and critical perspectives as we expand the scope, due to protective and public health concerns. This would also involve a third-party review of the evidence in terms of ethics and human rights compliance.

Gap: Capturing and Recognizing Different Types of Evidence and Experience in the MHSUH Sector. Different types of evidence and experience can inform care in the MHSUH sector, but first they need to be recognized and understood. Standards can help inform processes in order to capture and recognize the plurality of knowledge and innovation that traditional methods might overlook. Unconscious bias, systemic racism, colonialism, stereotyping, misinformation, and inequities can lead to misrepresentation or failure to reflect certain populations and nuances in the data collection and interpretation process.

Recommendation: Using a diverse and inclusive approach, develop standards that define and establish what evidence entails, how experience can inform evidence and be recognized in a way that leaves no one behind in the provision of MHSUH care.

Organization(s): Canadian Centre on Substance Use and Addictions, Canadian Institute for Health Information, Wellesley Institute, Thunderbird Partnership Foundation, First Nations Health Authority, Black Health Alliance, Health Care Can, Statistics Canada, community-based agencies, non-profit organizations, universities, The Canadian Network for Research in Schizophrenia and Psychoses, Psychosocial Rehabilitation Canada.

Issue 3 - Accountability and Evaluation Mechanisms

Accountability mechanisms are structures ensuring responsibility and oversight, holding individuals or entities answerable for their actions and duties in MHSUH services. In the overall governance structure and decision-making process, clients need to be involved in one way or another.

Evaluation mechanisms are processes to assess and analyze the performance, effectiveness, and quality of MHSUH services through data collection and analysis, enabling improvements and informed decision-making. Evaluation also features prominently when it comes to outcomes and impact of healthcare services. It ensures that the services provided are regularly assessed to deliver the intended impact and outcomes for clients.

Accountability and evaluation mechanisms are vital in MHSUH services for ensuring high-quality care. They enable the assessment of service quality, client satisfaction, and safety, aiding in the identification of effective interventions and areas needing improvement. By fostering transparency and accountability, these mechanisms ensure adherence to standards and equitable care delivery. They also help allocate resources effectively, reduce disparities in healthcare, within these services. Ultimately, these mechanisms play a crucial role in delivering effective, safe, and equitable care while striving for ongoing enhancement and innovation in mental health and substance use services.

When it comes to Indigenous communities, accountability and evaluation mechanisms can help address accessibility and disability issues. For instance, aspects of psychology and certain psychological frames do not currently meet the needs of First Nations communities in Canada as it is largely based on colonial constructs and concepts and deeply westernized. Several cultural considerations are not factored in when diagnosing a client with mental illness from these communities. Safety mechanisms and review processes can be instrumental in monitoring and assessing service providers.

Data sharing among various stakeholders including clients, health professionals, caregivers, and the wider community is crucial. Standardizing evaluation timelines, performance indicators, and specifying accountability within guidelines are key factors. To ensure comprehensive and inclusive standards, families, caregivers, and individuals who are receiving services should be involved in the beginning, the middle, and the end of the ongoing process of developing standards on accountability and evaluation mechanisms.

Interoperability refers to the ability of different systems, organizations, and clients/caregivers to work together seamlessly, accessing, exchanging, and using information in a coordinated and effective manner. Assessment of healthcare system interoperability should include clients, caregivers, healthcare teams and all parties concerned, and should be carried out using inclusive information technology founded on observance of clients' rights.

Gap: Standardizing Inclusive Accountability and Evaluation Mechanisms to Achieve High-Quality Mental Health, Substance Use Health, and Mental Illness Care. Standards are needed to indicate how accountability and evaluation mechanisms can be effectively implemented in the MHSUH sector. In some cases, current guidelines may not ensure equal participation of all parties, including people with lived and living expertise, in the evaluation of the MHSUH system. These guidelines may not promote transparency, equity and satisfaction for all types of clients, including those with mental illness; neither align with a person-centred approach to care.

Recommendation: Develop standards for inclusive accountability and evaluation mechanisms to achieve high-quality mental health, substance use health and mental illness care.

Organization(s): British Columbia Ministry of Health and Addictions, Health Standards Organization, Canadian Centre on Substance Use and Addiction, The Mental Health Commission of Canada, Community Addictions Peer Support Association, Canadian Institute for Health Information, Statistics Canada, Public Health Agency of Canada, Canadian Association of Community Health Centres, Canadian Institutes of Health Research.

Issue 4 - Human Rights and Substantive Health Equity

Inequitable or limited access to healthcare infringes on an individual’s human rights. Incorporating the notion of human rights and equity, as well as accountability mechanisms into MHSUH standards, will help create and continue to provide a safe and inclusive healthcare system that does not disadvantage people in certain social conditions and reduces harm overall.

Equity concerns everyone, including those who are Black, Indigenous and People of Colour (BIPOC), 2SLGBTQIA+ people, newcomers, linguistic minorities, and other marginalized communities as well as dominant groups. One additional route to equity in MHSUH is to ensure that standards reinforce access to health services for everyone in Canada. To help evolve existing standards and best practices, the recognition and integration of First Nations, Inuit, and Métis and Indigenous knowledge systems is also crucial.

Rights-based policies need to be strengthened in the Canadian MHSUH sector. These policies must take into account not only disparities, but also the specific values, needs and aspirations of individuals, based on their culture and traditions. At the initial stages of intervention, clients must receive the most comprehensive care possible, to avoid unnecessarily restrictive measures and avoidable hospitalizations. Canada needs to align itself more closely with the UN's human rights strategies for health care in terms of engaging with clients, creating safer and less restrictive environments, and respecting human rights in the delivery of services[1]. There should be more alignment and consistency between jurisdictions in respecting the human rights of clients and providing recourse for those who feel they have been subjected to unfair measures, as there are not always fair and equitable ones.[2]

Self-determination and the exercise of free choice must be respected when clients can make their own healthcare treatment decisions.

The deinstitutionalization of MHSUH services and the development of person-centred, rights-based community mental health services may be instrumental in ensuring health equity. Many people may be homeless due to a lack of institutional support as well as an absence or limited community support.

There is a gap in the quality of MHSUH services between mental health care provided by the public sector and that provided by the private sector. Regardless of where a person accesses care, they should be able to access services of equal quality and standards.

Gap: Aligning with Human Rights and Substantive Health Equity in MHSUH Care. Rights-based standards are needed to guide an equitable MHSUH care system that creates safer and less restrictive environments, encourages self-determination and the exercise of free choice, and respects everyone's right to health. By drawing on existing guidelines in this field, standards can close the equity gap in the delivery of services and care, in both the public and private sectors.

Recommendation: Develop standards that provide guidance on how to implement health equity for everyone and place people's right to health at the center the provision of MHSUH services, care, and treatment.

Organization(s): Supreme Court of Canada, Public Health Agency of Canada, Indigenous Services Canada, Black Health Alliance, House of Commons, Mental Health Commission of Canada, Canadian Mental Health Association, Health Standards Organization.

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[1] See Convention on the Rights of Persons with Disabilities (CRPD)Article 25 – Health: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-25-health.html

Issue 5 - Harm Reduction Principles and Approaches

The integration of the harm reduction principle into MHSUH (MHSUH) standards must be harmonized with the promotion of equity, access, autonomy, self-determination, and dignity. Harm reduction needs to be integrated into the day-to-day practices of healthcare professionals to help people be well, and feel better, in the way that suits them best. Harm reduction also exists along the entire continuum of MHSUH care outside of the health care system such as in social services and housing. While prioritizing individual autonomy and well-being may raise conflicts in certain cases, harm reduction must be mainstreamed into person-centred MHSUH standards, that respect and prioritize people's autonomy and well-being, and create safe, non-stigmatizing services, care, and treatment. It adopts a principle of incrementalism towards less harm and better health. Harm reduction care should also adopt a trauma-informed approach. It would facilitate the recognition of both the historical and intergenerational trauma experienced by First Nations, Inuit and Métis Nations and encountered by individuals and communities in different settings.

Harm reduction is not a one-size-fits-all solution and must be based on individuals' decisions. Harm reduction strategies can be utilized for clients interested in reduction, cessation or no changes in substance use patterns. It is necessary to meet clients where they are and tailor their choices to the services available, while also ensuring a safe and respectful work environment for healthcare providers. Applying harm reduction strategies as part of a person and people centred approach would reduce the barriers clients face when they need medical support. Harm reduction will not work in the same way for everyone. It needs to be articulated considering people's different levels of capacities, identity, social conditions, medical or mental health co-morbidities. Health services must not be interrupted or terminated if clients fail to comply with a code of conduct or the rules of the facility. The principle of harm reduction is reducing harm to anyone, therefore there is a need to balance client accountability, services, health professionals' and individuals' needs, along with the challenges of communities in which clients evolve.

People's ability to comprehend risk and make informed decisions may change over time. Their perception of their situation may not align with those of their family, chosen family and trusted carers. The MHSUH system has a responsibility to protect an individual's autonomy while balancing its responsibilities under each jurisdiction's rules and regulations regarding a person's capacity. The use of peer-led harm reduction strategies has proven effective in helping clients access safe supplies and prescriptions and raise awareness. A promising protective approach is peer-led intervention, which can help inform people about healthcare when they are disconnected from services, either for fear of being judged or stigmatized, or because of their geographical location. This model could be enhanced to promote client's contact with the healthcare system, as well as access to and monitoring of medication, with the aim of reducing the risk of overdose and death. It is also important to inform the public about harm reduction strategies such as life-saving courses, overdose reversal medications (i.e., naloxone kits) and safe places for substance use. The inclusion of people with lived and living expertise, family and community members helps to inform service assessment, improve access, and overall reduce harm.

Harm reduction practices should be part of a comprehensive, integrated approach that links services, facilitates the co-location of health services, and mitigates the risks associated with substance use, such as contamination by infectious diseases including HIV. Regarding rural communities' access to services, there is a need to increase access to services and strengthen the nursing stations, especially for the First Nations community services. There are gaps when it comes to creating links in small communities to access services, the inventory of health services and professionals are few and far between.

Definition of harm reduction:

The working group members have adopted the definition from Harm Reduction International[3] and added additional components. They deemed that Harm Reduction International's definition encompasses what harm reduction represents overall rather than being limited to substance use only. It also captures the intersection of all the factors that impact reducing harm as well as health promotion and prevention. A combination of part of this definition from Harm Reduction International that also included the working group member's inputs resulted in the following:

Harm reduction is grounded in justice and human rights. It focuses on positive change and on working with people without judgement, unnecessary coercion, discrimination. In the context of substance use, harm reduction refers to policies, programs and practices that aim to minimize the negative health, social and legal impacts associated with substance use, substance policies and substance laws and other health issues. Nevertheless, harm reducing standards should be adopted to specific situations as there are many layers to consider such as safety issues. Harm reducing principles should not be limited to clients and health providers but also the communities (families, peers, caregivers etc.) impacted by clients' health.

Gap: Implementing harm reduction principles and approaches in the MHSUH sector. Standards are needed to indicate how harm reduction principles can be extensively implemented in a way that takes into account the particularities of clients and best serves them when receiving and seeking healthcare. These harm reduction standards can ensure that services are provided based on a safe, non-stigmatizing, person-centred and inclusive approach, and provide guidance on best practices for respecting clients' autonomy while preserving their life and health.

Recommendation: Develop standards that provide specific guidance for the implementation of harm reduction principles and approaches in mental health, substance use health and mental illness care, while recognizing the need to regularly revisit these guidelines for an effective and evolving health care system dedicated to harm reduction for all, across Canada

Organization(s): Community Addictions Peer Support Association, Health Standard Organization, First Nations Health Authority, Metis National Council, Canadian Centre on Substance Use and Addiction, Mental Health Commission of Canada, Black Health Alliance.

Issue 6 - First Nations, Inuit, and Métis Knowledge Systems and Inherent and Treaty Rights

First Nations, Inuit, and Métis (FNIM) Nations have their own unique and distinct knowledge systems. Weaving these systems into health standards will safeguard the human rights, address anti-Indigenous racism and foster cultural safety for FNIM communities receiving MHSUH services, care, and treatment. Traditional Indigenous ways of healing and knowing are not fully integrated within the existing healthcare system, as the knowledge, practices, and values of FNIM communities need to be endorsed and reflected more systemically. FNIM data should be governed and owned by the inherent and/or treaty rights-holders, including members of the FNIM communities, and their chosen and self-determined Indigenous governments.

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[3] https://hri.global/what-is-harm-reduction/

First Nations, Inuit, and Métis are distinct s. 35 Rights holders in Canada. Pan-Indigenous policies and language undermine First Nations, Inuit, and Métis work toward self-determination and self-governance. FNIM groups have their own distinct cultures, beliefs, values, ways of life, knowledge systems and governance structures in seeking self-determination. Measures to redress the inequities present for one nation do not necessarily equate to positive outcomes for another.

When it comes to advancing FNIM priorities within government initiatives, the focus should be on the government's alignment with the Nations' momentum and current challenges through a decolonizing lens, rather than a paternalistic, prescriptive and western approach. In the national initiatives, FNIM voices are brought to these conversations in a colonial, tokenistic manner rather than as self-determining governments. Greater government funding and equitable funding would create safe spaces for First Nations, Inuit, and Métis reconciliation.

As a representative of the Crown, Canada has fiduciary responsibilities to First Nations based on treaties and section 35 of the constitution. Canada also has a fiduciary duty to Métis based on section 35 of the Constitution. Inuit beneficiary status is determined through its four Treaty Organizations. The Canada Health Act is another instrument that defines the Provincial and Territorial government responsibilities for MHSUH for every person, not excluding First Nations, Inuit and Metis populations or detracting from their rights as defined in section 35 of the Constitution and Treaties. [4]

The integration of nation distinctions-based national policies and standards would ensure inclusion, equity, and access to health services for all FNIM peoples. In this respect, a promising approach would be to involve national and provincial representative FNIM organizations and governments in all Indigenous-related matters.

Gap: Integrating First Nations, Inuit, and Métis Knowledge Systems and Inherent and Treaty Rights into MHSUH Services, Treatment, and Care. Standards are needed for a recognition and application of existing MHSUH community standards and norms of First Nations, Inuit, and Métis communities. Pan-Indigenous policies and language undermine First Nations, Inuit, and Métis work toward self-determination and self-governance. FNIM MHSUH data should be governed and owned by the inherent and/or treaty rights-holders and their chosen and self-determined FNIM governments.

Standards should be explicit as to how "equity" is defined and applied and assessed in conformity assessments and compliance with such standards. Further, these processes should articulate how actors of conformity assessments and standards reviews are prepared to support such activities with an equity focused lens. Conformity assessment processes and standards compliance should promote an understanding and assessment of its own inherent biases and actions of epistemic racism in order to ensure that inequity is not ignored, that often results in further inequity through the conclusion of a review of standards, and conformity assessment for service providers.

Recommendation: Develop standards for the delivery of MHSUH services specific to the needs of First Nations, Inuit, and Métis, and adapted to the distinct needs of their communities as distinct rights holders.

Organization(s): First Nations Health Authorities, Métis National Council, Inuit Tapiriit Kanatami, Assembly of First Nations, Thunderbird Partnership Foundation, First Peoples Wellness Circle, First

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[4] It was noted that Mental Health and substance use services currently covered under the Canada Health Act include care provided in hospitals (e.g. Emergency rooms) and physical services provided by psychiatrists. Many mental health services are community-based, and therefore not covered under the Canada Health Act, but rather provided at the discretion of the Provinces and Territories on their own terms and conditions.

Nations Health Managers Association, Indigenous Services Canada, Truth and Reconciliation Commission of Canada, Canadian Institute for Health Information, Health Standards Organization, The Mental Health Commission of Canada.

Issue 7 - Privacy and Confidentiality Related to MHSUH

Current legislation on protecting the privacy and confidentiality of clients seeking or receiving MHSUH care raises sensitive situations that standards can strengthen to ensure effective and continuous access to care for all. In many cases, it may be challenging to respect the privacy and confidentiality of children and young people, minorities or small communities dependent on urban centers, and people with mental illnesses or concurrent disorders.

In the MHSUH sector, the sharing and dissemination of information, as well as respect for privacy and confidentiality, must be coordinated equitably between the client and service providers. Standards can be developed around the need to ensure shared responsibility between the client and healthcare professionals regarding access to and control of private and personal information. Standards can be an excellent tool for reinforcing the training of hospital staff in privacy legislation. Such training is necessary to distinguish how caregivers may share collateral background facts with health care professionals, while these professionals must not disclose confidential information. In view of provincial and territorial health information protection legislations, respect for clients' privacy choices must always be observed in any relationship between a client and healthcare providers. Currently, each province's and territories’ mental health acts set out that a person could be determined to lack particular decision-making capacity, while also outlining the steps to provide support for decision-making. Taking extra time to fully explore each client's individual situation regarding their specific limitations is essential to safeguarding the MHSUH of all clients. More frequent use of commonly accepted standard scales would foster consistent methods across Canada.

Another aspect concerns the family's privacy rights and how they are taken into account by healthcare providers. Families can provide vital information that providers may not be aware of, but which could save a client's life. Standards can help develop guidelines on how healthcare providers can make informed decisions to consider collateral, potentially life-saving information, without undermining the trust between families and clients. There is a need for ongoing, dynamic dialogue between providers, clients, and families, while respecting clients’ privacy.

For First Nations, Inuit, and Métis communities, standards can be developed regarding the transition of private health information from one jurisdiction to another. There is a gap in this area. There should be jurisdiction-specific standards when it comes to making decisions about whether to involve families. Nunavut has updated its Mental Health Act, which also provides guidance on family involvement when a client is in crisis or seeking treatment. Community norms exist for sharing information and managing communications, as Indigenous peoples from remote, rural, and northern communities, for example, must go to urban centers to access MHSUH care. Timely and consistent communication is needed between clients and health professionals, as well as between services and jurisdictions. This is important when, for instance, clients need to travel for care or are in crisis, as well as for following up on treatment plans and medication.

Privacy and confidentiality related standards should also be developed based on cultural considerations and communities’ size and need to be addressed alongside access to care for all and inclusion.

Gap: Privacy and Confidentiality Related to MHSUH. The scope of this issue generated a large number of standards, most of them indirectly relevant or sector specific. The sector-specific standards mainly address environment and transportation concerns over the use of data. Moreover, most standards related to this issue are very granular and do not appear to go over the responsibilities of all actors involved in the data lifecycle in detail. As mentioned in the issue description, one of the principal concerns around this issue is to maintain trustworthiness from one actor to another and ensure ethical use throughout the data lifecycle. In fact, more than half of the standards generated from the search are associated with data collection, leaving few standards addressing the other components of the data lifecycle. However, it is interesting to note that more than one-third of the standards examined for this issue were developed in 2015 or after, which indicates strong standardization activities aiming to address this issue.

Recommendation: Develop standards to ensure shared responsibility between the client and healthcare professionals regarding access to and control of private and personal information and collection of collateral background facts. Develop jurisdiction-specific standards about the involvement of families while considering cultural difference and communities' features.

Organization(s): Mature Minors, Children's Hospital of Eastern Ontario, SickKids, Health Canada, Health Standards Organization, Mental Health Commission of Canada, Supreme Court of Canada, Mental Health Commission of Canada, Centre for Addiction and Mental Health, Canadian Centre on Substance Use and Addiction, International Organization for Standardization.

Issue 8 - Quality of Health Services Achievable by Effectively Addressing the Social Determinants of Health

The World Health Organization defines the social determinants of health as "the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. [..] Examples of the social determinants of health, which can influence health equity in positive and negative ways include income and social protection, education, unemployment and job insecurity, food insecurity, housing, basic amenities, and the environment."

The social determinants of health have a major impact on people's health and wellbeing. The government and society have a role to play in preserving health equity, reducing health inequalities, recognizing the social determinants of health, and ensuring that the healthcare system is equitable and interconnected and secures health for all. Effectively addressing the social determinants of health is crucial to reducing persistent health inequalities and correcting detrimental conditions. This requires action from all sectors and within civil society. A holistic approach should be adopted to ensure that the healthcare system plays its part in promoting well-being. Collaboration between different sectors of the government can help to improve clients' overall mental health, reduce mental illness, and improve access to health for all, including for people living in remote areas. In the case of Indigenous communities, it is essential to establish interactive synergies between communities, clients, and health care facilities. The incorporation of intersectionality in addressing health inequalities should be at the center of health guidelines, best practices, and standards.

Quality of health outcomes will not be achieved if the social support clients (including those disabled by their mental conditions) need is not combined with medical assistance and treatment. Standardization is an important conduit for providing guidance on how our healthcare providers can interact with other sectors to bridge gaps. Standards should not be limited to MHSUH providers, as individuals' well-being does not depend solely on the MHSUH treatment they receive, but also on other social factors such as housing. These standards should be formulated both at government level and within the healthcare system, and aim to provide opportunities for all, regardless of their economic and social conditions, race, gender, abilities etc. It is the government's responsibility to ensure that social determinants are addressed not as supplements, but as an integral part of an adequate MHSUH system.

A focus on the social determinants of health entails increased funding for healthcare services as well as an effective use of existing funding, and coverage of extended healthcare benefits. Currently, the healthcare system does not fully cover key and essential services for mental health, nor does it provide adequate and timely access to funded services such as primary care and psychiatry. These services are in part unsubsidized and privately payable. Furthermore, in the case of mental illnesses, there is not even access to private services. Provided that standards establish a correlation between the social determinants of health and the provision of quality services, standards should also define best practices at the initial identification of MHSUH issues, not just at the intervention stage.

Every human being has the fundamental right to quality healthcare. Standards should serve everyone towards equitable, person-centred quality care, considering the social determinants of health. An equitable and inclusive approach, aimed at ensuring that people receive quality care that is distinction-based and person-centred, is essential to achieving health for all.

Gap: Addressing Social Determinants of Health to Achieve Quality Health for All. Standards are needed to provide guidance on how the social determinants of health should be addressed, not as supplements, but as an integral part of an adequate MHSUH system. These standards should be formulated both at governmental level and within the healthcare system, aiming to provide opportunities for all and to serve everyone through the lens of inclusive, person-centred quality care.

Recommendation: Develop standards for the effective management of the social determinants of health to achieve quality health for all. These standards should establish a correlation between the social determinants of health and the provision of quality health services, and not be limited to the MHSUH sector.

Organization(s): Health Standards Organization, Centre for Addiction and Mental Health, Health Canada, Public Health Agency of Canada, Black Health Alliance, First Nations Health Authority, Inuit Tapiriit Kanatami, Wellesley Institute, Canadian Centre on Substance Use and Addictions, Métis National Council; Government of Canada; National Collaborating Centre for Determinants of Health, National Alliance to End Rural and Remote Homelessness, Canadian Network for the Health and Housing of People Experiencing Homelessness, Canadian Housing First Network – Community of Interest.

Issue 9 - Workforce Health, Trainings and Competencies

The World Health Organization[5] defines the health workforce as the health workers considered collectively. In the MHSUH sector, standards can help fill a number of gaps relating to workforce health, continuous training for quality service delivery and competencies' development.

It is important to extend psychological health and safety standards to the regular assessment of the health of healthcare workers themselves, regardless of their role. It is important to assess the mental and general health of healthcare professionals, as the mental health of the workers has an impact on the quality of the services they provide. Work-related burnout, for example, is common on the provider side under normal working conditions, and higher in times of crisis, as occurred during the COVID-19 pandemic.

Another area on which standards can focus is the social determinants of in-service workers[6]' health. This issue is often overlooked, even though it has a major impact on the quality of care provided. There is significant pay inequality across professions and functions in MHSUH healthcare systems. The workforce is often disproportionately composed of women, newcomers, and racialized people. This is one of the causes of pay inequality. This situation needs to be resolved within the health sector and in a coordinated manner, including for First Nations, Inuit, and Métis populations.

A compassionate and skillful workforce will stay healthier and longer in the field. Standards need to be implemented to assess and optimize the ethical competencies of healthcare professionals, by establishing mandatory values to be respected by all staff, such as the adoption of trauma-informed, equity-based, compassionate, dignified, non-stigmatizing, respectful, and person-centred care, practices, and approaches. Every interaction in the healthcare system has an impact on the client. This requires the application of standards that would support the obligation for the workforce to undergo regular training and assessment. These standards can mandate recurrent learning and updating of ethical competencies and create accountability measures that reinforce the application of these competencies. In the case of physical offences, verbal threats, harassment, bullying and so forth, policies, guidelines and standards should also provide means and channels to ensure that those concerned have recourse to address these situations. Such standards can also ensure the safety and protection of clients, healthcare staff, providers, families, and anyone else interacting with the healthcare system.

Standards can also support community-based and reconciliation approaches. There is a need to incorporate culturally relevant training for evidence-based therapies and support, to ensure meaningful engagement with marginalized voices.

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[5] World Health Organization. Health workforce. https://cdn.who.int/media/docs/default-source/health-workforce/hwp/202100608-health-workforce-terminology.pdf?sfvrsn=b5d2808d_3&download=true

[6] In-service workers are any form of on-the-job staff working to provide services.

Gap: Enhancing Workforce Health, Trainings and Competencies. Building on existing guidelines, standards are needed to provide guidance on addressing the social determinants of in-service workers' health, as well as their ethical competencies in the MHSUH sector. These standards would help develop a skilled workforce that would remain healthier and perform better. It would also promote the application of trauma-informed, equitable, compassionate, dignified, non-stigmatizing, respectful and caring care, practices, and approaches.

Recommendation: Develop standards to enhance the health, training, and competencies of the MHSUH workforce.

Organization(s): Canadian Centre on Substance Abuse, National Native Addictions Partnership Foundation, Health Standards Organizations, Canadian Coalition for Senior's Mental Health, Canadian Centre on Substance Use and Addiction, Health Canada, Public Health Agency of Canada, CSA Group, Canadian Federation of Mental Health Nurses; Canadian Interprofessional Health Collaborative; Canadian Psychiatric Association and College of Family Physicians Shared Mental Health Care Working Group; Canadian Association of Social Workers.

Issue 10 - Continuity and Transition of Care

Standardization can help enhance the continuity and transition of care. Harm-reducing and person-centred standards can help improve clients' use and experience of the healthcare system and reduce gaps and fragmentations detrimental to health.

Transition of care refers to the different points in health services provided to a client receiving care, as well as other types of transitions of care, such as those related to age groups and locations. Good practices, standards and guidelines should be implemented to structure the transition from one level of care to another (i.e. from testing to receiving results to undergoing treatment and aftercare), as well as the modalities of care; and all jurisdictions should achieve those guidelines. Transition of care standards can be developed to plan and facilitate with the client the transfer from communities to facilities (hospitals, treatment centers) and from facilities to communities. These point-to-point services are key vulnerable times of transition when caregivers or other family members could help ensure that clients must not be left unattended or neglected. Transitions of care must be well executed. In hospitals, a client may be considered medically fit for discharge, yet require considerable support to return to the community. This transfer rarely goes smoothly. Interprovincial transition planning is crucial for, and with clients, receiving care from different jurisdictions.

Continuity of care is the process of ensuring that the client benefits from an ongoing care that evolves according to the client's needs and based on a client-partnered treatment and approach. It refers to the care environment based on a person-centred approach. Standards on continuity of care in MHSUH would help to ensure that services are less fragmented to provide effective, quality medical care. Services would thus be interconnected, coherent for the client as well as integrating the client into the process and guaranteeing the quality of care over time.

Standardization can also help define integration, coordination, access, and accessibility, among other things. From the client's point of view to that of the physician, the modalities of coordination, for example, may differ. People have different understandings, experiences, expectations, and measures of these concepts. Primary care providers for instance tend to be reluctant to refer clients, which can be a major barrier to accessing treatment. It is necessary to ensure that clients know the right doors for their needs and services. The aim is to ensure that clients do not go to the wrong door and/or remain unserved.

Cultural barriers must also be taken into account when defining access to care for equity-denied communities. Prejudice, exclusion, and discrimination often lead to detrimental marginalization and reduced access to care for such communities.

Gap: Defining Key Concepts related to the Continuity and Transition of Care. Standards are needed to define key concepts related to continuity and transition of care in MHSUH. The definition of these concepts should include all concerned parties including the clients.

Recommendation: Complete work on continuity and transition of care based on the existing standards. These additional standards can focus on the development of consensus-based definitions of concepts that may have different interpretation from a client's point of to that of a physician such as: coordination, access, integration etc.

Organization(s): Health Standards Organization, Mental Health Commission of Canada, The Canadian Centre on Substance Use and Addiction, Health Quality Ontario, Canadian Institutes for Health Research, International Organization for Standardization; Association of Canadian Occupational Therapy Regulatory Organizations and Canadian Association of Occupational Therapists.

Working Group 2: Primary Health Services Integration

Issue 11 - Timely Access to MHSUH Care

People have the right to timely access to mental health care and substance use health care. Access to this care should be coordinated with primary health services, which offer opportunities for health promotion, prevention, screening, and early intervention. This can help identify and address issues before they reach crisis levels. As much as possible, care should be provided in a person's own community. Discussions of mental health and/or substance use health should be supportive, person-centred, trauma-informed, stigma-free, seamless (i.e., without fragmentation or service gaps), and leverage a stepped-care (or similar) approach to providing care.

Efforts must be made to reduce barriers to MHSUH care, including through "single-window" access points that leverage diverse skills of different health professionals (i.e., psychotherapists, nurse practitioners, clinical social workers, peer support workers, registered psychologists, certified counsellors, occupational therapists [note: this is not an exhaustive list]) in a team-based care approach. There should be no "wrong door" to access mental health and/or substance use health care. Interventions should prioritize flexibility, offering personalized care that is tailored to an individual's needs and circumstances (i.e., no one-size-fits-all approaches) and helping people access the most appropriate health professional(s) at the right time. Best practices and approaches for screening and early intervention should be gleaned from successful evidence-based approaches for other health issues, such as diabetes and chronic obstructive pulmonary disease. Social determinants of health must also be understood for individuals seeking care, and social supports should be leveraged to help improve health. Consideration also needs to be given to how funding follows an individual through the care system; private funding should not lead to greater access than public funding.

Particular consideration needs to be given to how technological tools, connected to or supported by qualified health services providers, can help improve access to MHSUH care systems without introducing or entrenching barriers (e.g., poor internet connectivity in rural or Northern communities).

Improving widespread access to mental health care and substance use health care will also require addressing funding, including a modernization of billing codes to incentivize improved MHSUH services. Efforts must also be made to ensure fair and equitable remuneration for health care professionals in urban areas compared to rural, remote, and Indigenous communities. Better accountability may be achieved through measuring health outcome gaps between specific populations and setting benchmarks to reduce gaps and improve access and outcomes for underserved populations.

NB: “Primary Care and Primary Health Care are very similar terms which are often employed interchangeably, but which are also used to denote quite different concepts. Much time and energy is spent discussing which term is the appropriate one for a particular application. There is a growing recognition internationally that the two terms describe two quite distinct entities. Recent Canadian uses of the two terms are, for the most part, consistent with the international uses. Primary Care, the shorter term, describes a narrower concept of "family doctor-type" services delivered to individuals. Primary Health Care is a broader term which derives from core principles articulated by the World Health Organization and which describes an approach to health policy and service provision that includes both services delivered to individuals (Primary Care services) and population-level "public health-type" functions.[7]”

Gap: Improving Access to MHSUH Services. People have the right to timely access to MHSUH care, and this can be delivered in part through improved coordination with primary health services and improved screening and early intervention techniques. Guidance should be developed that collects best practices in a way that offers a pathway to improved MHSUH outcomes for all people in Canada.

Recommendation: That guidance be developed to help improve access to MHSUH services, particularly through better connections with the primary health services system.

Organization(s): Stepped Care Solutions, Canadian Mental Health Association, Canadian Health Research Institute, Canadian Institute for Health Information, Health Standards Organization, CSA Group, Digital Governance Standards Institute, Community Addictions Peer Support Association, Mental Health Commission of Canada, Centre for Addiction and Mental Health.

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[7] Source: Muldoon LK, Hogg WE, Levitt M. Primary care (PC) and primary health care (PHC).What is the difference? Can J Public Health. 2006 Sep-Oct;97(5):409-11. doi: 10.1007/BF03405354. PMID: 17120883; PMCID: PMC6976192

Issue 12 - Continuum of Care

Health care includes MHSUH. There is a need for more integration throughout the continuum of care, encompassing education, health promotion, prevention, early intervention, public health, primary care, acute care, treatment, aftercare, and community support and social determinants of health. Better integration throughout this continuum, and particularly between primary care, mental health care, and substance use health care, will help ensure that people receive seamless care that considers their whole person.

Primary care providers are well-placed to support health promotion, education, and early intervention for MHSUH (including behavioural addictions). Interactions should include stigma-free, trauma-informed discussions of an individual's MHSUH, provide information and options when appropriate, and offer referrals to specialists as needed, based on the desired health outcomes of the individual seeking care. A stepped-care approach can provide appropriate support. Individuals shall have agency and the opportunity to make informed choices about their health and potential interventions or treatment; a health care navigator may help in this regard. Providers need to have the tools and information that will enable them to provide this whole-person health care. Care must be informed by individual circumstances, including an individual's capacity to make an informed choice. Family, chosen family, or caregivers often have a role to play in this process. Consideration may be given to an individual's family, chosen family, and/or caregivers and the role that they may play in health decisions. Consideration must also be given to the continuity of care for individuals moving between jurisdictions (i.e., across provincial or territorial borders).

Mental health care and substance use health care need not always be provided in tandem, but consideration should be given to co-occurrence and the possibility that issues with one may lead to issues with the other (i.e., substance use to overcome mental health issues, mental health issues stemming from substance use). Abstinence-based approaches do not work for all individuals and present a barrier to access to care; people should be able to access care even (perhaps especially) when they are experiencing symptoms of their illness(es) related to substance use health or mental health.

Integration of the primary care, mental health care, and substance use health care systems does not require amalgamation, but improved connections need to be made between them. For example, when an individual seeks care for a physical health issue that resulted from mental health issue or substance use health issue, they should have an opportunity to pursue and receive care for that underlying issue. Harm reduction should be a key tenet of the continuum of care, for mental health as well as substance use health. Consideration also needs to be given to how funding follows an individual through the continuum of care; private funding should not lead to greater access than public funding. Greater transparency and pan-Canadian standards on the costs of providing service can improve access and equity. Funding mechanisms may be able to incentivize improvements to quality of care for physical health, mental health, and substance use health.

Distinct but linked Key Issues:

- Working Group 4, "Continuum of Care for People with Complex Needs"

Gap: Integrating the Continuum of Care to Improve Access and Health Outcomes. There is a lack of guidance on how to integrate services across the continuum of care (and particularly between primary care, mental health care, and substance use health care) to provide health care that considers the whole person.

Recommendation: That standardized guidance be developed to outline how best to integrate the continuum of care—encompassing education, prevention, early intervention, public health, primary care, acute care, treatment, aftercare, and community support and social determinants of health—to improve equity and access to mental health care and substance use health care for people in Canada.

Organization(s): Stepped Care Solutions, Canadian Mental Health Association, Canadian Health Research Institute, Canadian Institute for Health Information, Health Standards Organization, CSA Group, Community Addictions Peer Support Association, Mental Health Commission of Canada, Centre for Addiction and Mental Health; Peer Support Canada.

Issue 13 - Quality Assurance for Digital MHSUH Applications

Digital applications (apps) can provide MHSUH support to people in Canada, including those who may be seeking discrete health care support due to stigma or other concerns. Digital apps also have the potential to connect people to additional support as needed. However, given the number of applications in the digital marketplace, third-party evaluation and conformity assessment can provide certainty of adherence to quality standards and data privacy and security requirements (including around the use of artificial intelligence). Assessment frameworks must also ensure that any health advice is evidence-based, credible, trauma-informed, is rooted in anti-stigma and anti-racist principles, and respects data privacy (including Indigenous data sovereignty).

There are several current and emerging formats provided through digital MHSUH apps, such as: self-help apps, provider-guided support apps, and full virtual care apps. Conformity assessment schemes should consider these formats separately and identify unique requirements each one may have. To ensure appropriate care is provided, special consideration may be required related to: for-profit apps; apps that contain advertisements; and apps that rely on artificial intelligence.

Given extensive work that has been done and is underway by multiple organizations, particularly by the Mental Health Commission of Canada and the Homewood Research Institute, there may be an opportunity to establish a conformity assessment scheme to certify digital MHSUH apps. Apps which receive third-party certification would be recognized as reliable by both people seeking support and health care professionals looking to make recommendations to individuals to whom they are providing care.

Gap: Conformity Assessment of Digital MHSUH Applications. Third-party conformity assessment of digital MHSUH applications can provide people seeking care and care providers with certainty on the quality of apps available in the digital marketplace, specifically about which apps meet minimum requirements.

Regulatory Considerations: Privacy regulations, Data security regulations, Data sovereignty regulations (including Indigenous data sovereignty), Potential regulations mandating certification.

Conformity Assessment Considerations: Given that assessment frameworks exist, validation and conformity assessment are the next logical step to implementing these quality standards

Recommendation: That the feasibility of establishing a conformity assessment scheme for digital MHSUH apps be examined and, if appropriate, that the scheme be established.

Organization(s): Canada Health Infoway, Mental Health Commission of Canada, Health Standards Organization, Organization for the Review of Care and Health Apps, CSA Group, Canadian Centre for Substance Use and Addictions, Homewood Research Institute, Digital Governance Council Institute, International Organization for Standardization.

Issue 14 - Behavioural and Technical Competencies and Workforce Development for Those Involved in MHSUH Care for People in Canada

The MHSUH workforce is broad, and it includes first responders (e.g., police officers, paramedics), health care providers (e.g., physicians, clinical psychologists, registered social workers, psychotherapists, registered nurses, nurse practitioners, occupational therapists), community health workers (e.g., health advisors, outreach educators, peer support workers), and can even be thought to include a person’s family, chosen family, or caregivers. Establishing standardized curricula, training, behavioural competencies, technical competencies, and other supports, through a co-design model, can help ensure that support and care for those seeking it is equitable, trauma-informed, free of stigma, free of discrimination, empathic, identity-affirming, culturally affirming, and supportive. These tools can ensure there is accountability for individuals and organizations, including those that see themselves as outside the MHSUH care system.

Significant work has been done by public, private, and third-sector organizations (within Canada and internationally) in developing guidance on competencies and workforce development for these fields. There is an opportunity for this guidance to be aggregated, validated, and optimized by co-developing a series of consensus-based standards or guidance documents, featuring input and guidance from a diverse range of interested parties (including the centring of marginalized communities, such as people with lived and living expertise). This process can help remove stigma and unconscious bias from the MHSUH workforce.

An additional consideration may be the establishment of organizational competencies, to ensure that organizations even peripherally involved in MHSUH care have guidance enabling them to establish supportive cultures that promote MHSUH and safeguard the health of their staff and clients. Mental health first aid could be a component of this guidance.

Similarly, there is an opportunity to co-design training, guidance, tools, and support for the family, chosen family, and caregivers of those seeking care for mental health or substance use health issues. These close individuals are often instrumental in supporting an individual's wellness journey, but they need to be given the support they need if they're to support their loved one.

In the spirit of "training the trainer," care providers and associated support staff should have the appropriate training and resources for family/chosen family so they can help provide support for a loved one seeking care. This may include tools to help respond to or overcome stigma (including cultural stigma) around mental health and/or substance use health issues.

Gap: Behavioural and Technical Competencies and Workforce Development for Those Involved in MHSUH Care of People in Canada. The MHSUH workforce is broad, and it includes first responders, health care providers, community health workers, and can even be thought to include a person's family, chosen family, or caregivers. Establishing standardized curricula, training, behavioural competencies, technical competencies, and other supports, through a codesign model, can help ensure that support and care for those seeking it is equitable, trauma-informed, free of stigma, free of discrimination, empathic, and supportive.

Regulatory Considerations: Federal and provincial human rights legislation; Federal and provincial accessibility legislation

Recommendation: That a series of standardized guidance be developed prescribing behavioural and technical competencies for workforces involved in safeguarding the MHSUH of Canadians.

Organization(s): Canadian Centre on Substance Use and Addictions, CSA Group, Health Standards Organization, Federal/provincial/territorial licensing bodies, Canadian Mental Health Association, Mental Health Commission of Canada, Canadian Institute of Health Research, Canadian Patient Safety Institute; Canadian Federation of Mental Health Nurses; Canadian Association of Occupational Therapists.

Issue 15 - Mobile Crisis Response/Mobile Crisis Care

When individuals experience mental health or substance use health crises, their need for care is urgent. Mobile crisis response units may be able to respond to these instances and help stabilize the person experiencing the crisis in a timely fashion and/or transport them to a facility that can help provide necessary care. The mobile nature of these units may also mean that care is more readily available when an individual is ready to seek help.

There may be a variety of mobile crisis response units that can be established and deployed, including mental health teams, substance use health teams, overdose response teams, paramedic teams, or some combination of those specialties. These units may have specialized vehicles or equipment available. Having specific mobile crisis response units can help relieve some strain on ambulances and emergency rooms, while also providing more specialized care for individuals experiencing mental health or substance use health crises. Deployment of crisis response units should be harmonized/coordinated with other first response services to ensure that emergencies are responded to in a timely way and with the appropriate resources. Consideration should be given to what vehicle markings may be most appropriate to respect client confidentiality.

Consideration must be given to follow-up care, once the individual experiencing a health crisis is stabilized. In conversation with the person seeking care and with their ongoing consent, the mobile crisis responders should arrange for ongoing care and support to respond to underlying health issues that may exist (including screening to help identify potential health issues). Further work should examine whether and how mobile crisis response can help improve care in remote, rural, and northern communities. Mobile crisis response units have been established or piloted internationally (e.g., in the United Kingdom, Sweden) and in Canada (e.g., Alberta, Ontario). National guidance should incorporate the best practices and lessons learned from these jurisdictions, and examine local requirements to provide optimal care to the community (or communities) being served.

Gap: Guidance for Establishing Mobile Crisis Response Units for MHSUH. When individuals experience mental health or substance use health crises, their need for care is urgent. Mobile crisis response units may be able to respond to these instances and help stabilize the person experiencing the crisis in a timely fashion and/or transport them to a facility that can help provide necessary care. The mobile nature of these units may also mean that care is more readily available when an individual is ready to seek help.

Regulatory Considerations: Federal and provincial human rights legislation; Federal and provincial accessibility legislation

Recommendation: That national guidance be developed on how to establish, manage, and coordinate mobile crisis care units to provide care for individuals experiencing MHSUH crises.

Organization(s): Canadian Centre on Substance Use and Addictions, CSA Group, Health Standards Organization, Canadian Mental Health Association, Mental Health Commission of Canada, Canadian Institute of Health Research, Canadian Patient Safety Institute, Paramedic Association of Canada.

Working Group 3: Children and Youth

Issue 16 - Youth-Partnered Care

Young people[8] have unique, specific needs for MHSUH interventions, and there are concerns associated with adopting adult-centred interventions for this age group. This is particularly true for youths with complex needs (including [but not limited to] those who are pregnant, experiencing human trafficking or homelessness, those with concurrent MHSUH needs, are in foster care or correctional institutions, have developmental or cognitive delays, have behavioural addictions [e.g., gaming, pornography, social media], or who experience other complex issues related to matters of consent). Care providers shall meaningfully engage and partner with young people in their care on an ongoing basis, so that young people understand their health and their options and can determine the most appropriate care interventions. This partnership shall focus on building a trusting relationship, prioritize ongoing informed consent (including the ability to withdraw consent), and shall continue throughout the health care journey.

The United Nations defines youth as, “the period of transition from the dependence of childhood to adulthood’s independence[9].” This is a broad range that includes young people at different developmental stages (e.g., the needs of a typical 13-year-old are different from a typical 23-year-old), so the circumstances of individuals shall have a significant influence on the direction of interventions, in keeping

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[8] Note: “Youths” and “young people” are used interchangeably

[9] https://www.un.org/en/global-issues/youth#:~:text=There%20is%20no%20universally%20agreed,of%2015%20and%2024%20years.

with the concept of a partnership with the young person in determining the direction and desired outcomes of any interventions pursued.

Young people may have specific needs for: when interventions are available (e.g., evenings outside of school hours); their life stages; developmentally appropriate knowledge translation of information to ensure an understanding of potential interventions across different age groups; consent and privacy, including in relation to family and caregivers. Additional considerations should be made for a young person's individual circumstances, including culture, language, gender, sexuality, spirituality, and other factors that could impact their health needs.

Prevention and positive coping strategies shall be prioritized. Interventions shall reflect evidence-informed care, broadly defined to include practice-based evidence, wise practices, traditional knowledge and lived and living expertise. Interventions shall also be developmentally appropriate and informed by the young person's individual circumstances, including their capacity to consent. The youth-partnered model shall take a strengths-based approach, be delivered without stigma or judgment, and emphasize the importance of real, positive outcomes for young people.

Distinct but linked Key Issues:
- Working Group 1: Human Rights and Substantive Health Equity
- Working Group 2: Timely Access to MHSUH Care
- Working Group 4: Person-Centred Health Care and Co-Creation of Care

Gap: Guidelines for Meaningfully Partnering with Young People in Decisions for MHSUH Care Interventions. Young people have unique, specific needs for MHSUH interventions, and there are concerns associated with adopting adult-centred interventions for youth. Guidance is needed for care providers in identifying how to meaningfully partner with young people in their health care in a way that respects the autonomy, humanity, and individuality of each youth.

Regulatory Considerations: How this may affect provincial Child and Family Services licensing and youth in care. How this may affect legislation around mandatory treatment/mandatory youth withdrawal management services (including issues of consent).

Recommendation: That a normative document be developed that will (A) outline what young people can expect from care providers when seeking mental health and/or substance use health interventions, and (B) provide guidance to care providers on how to partner with and meaningfully engage young people in their health care decisions.

Organization(s): Federation of Integrated Youth Services Networks; Foundry; Youth Wellness Hubs Ontario; Aire Ouverte; ACCESS Open Minds; Huddle Manitoba; Health Standards Organization; Canadian Institutes of Health Research; Knowledge Institute on Child and Youth Mental Health and Addictions; CSA Group; Graham Boeckh Foundation; We Matter; Canadian Roots Exchange.

Issue 17 - Promoting Access to Equitable and Culturally- and Identity-Affirming Youth-Partnered Care

Young people need access to MHSUH care that is equitable, culturally- and identity-affirming, socially just, and youth-partnered. This care must take a strengths-based approach, be trauma-informed, be actively antiracist, and work to address stigma, structural violence, and colonial violence if it is to be truly equitable.

Fostering and encouraging youth agency is an important initial step in this process. This requires that the young person be empowered to identify their health care goals and desired outcomes. To make informed choices related to their health, young people need to be given time and space to consider their options. Capacity building and knowledge translation may be necessary to ensure the young person understands the options they have in improving their health and is able to co-design the approach to wellness; a health care navigator may help in this regard. It is also important that consideration be given to a young person's first language, and interpretation services should be made available (including for individuals who are nonverbal or minimally verbal). This empowerment must also be informed by a young person's individual circumstances, including their capacity to make an informed choice. Family or caregivers often have a role to play in this process.

Young people often must wait to access services due to inadequate availability, and this needs to be addressed. Integrated care and a stepped-care model can help ensure wait times are reduced. A significant barrier to access, however, is inadequate and inequitable funding for MHSUH services; this must be addressed if the needs of young people are to be met.
Special consideration shall also be made for young people who are or have been involved with the corrections system to ensure their agency and perception of safety is respected and that the care they receive is culturally- and identity-affirming, meets their needs, and helps them achieve their self-identified desired health outcomes.

It is also important to recognize that cultural ways of healing can be just as valuable as Western practices, particularly for young people who are away from their home communities. Access to culturally affirming care can provide young people with the necessary tools to effectively address MHSUH issues and shall be discussed and made available to young people.

Finally, it is important to recognize the social determinants of health, and that a young person's basic needs (food, safe housing, personal security) need to be met before they will be able to effectively pursue a healthy life.

Distinct but linked Key Issues:

- Working Group 1: Different Types of Evidence and Experiences
- Working Group 1: Human Rights and Substantive Health Equity
- Working Group 1: First Nations, Inuit, and Métis Knowledge Systems and Inherent and Treaty Rights
- Working Group 1: Quality of Health Achievable through Effective Management of Social Determinants of Health
- Working Group 2: Timely Access to MHSUH Care
- Working Group 4: Person-Centred Health Care and Co-Creation of Care

Gap: Guidance for Providing Access to Equitable and Culturally- and Identity-Affirming Youth-Partnered Care. Young people need access to MHSUH care that is equitable, culturally- and identity-affirming, socially just, and youth-partnered. Care providers shall empower young people through capacity building and knowledge translation to ensure they are able to make informed choices to pursue health care that aligns with the young person's identity and desired outcomes.

Regulatory Considerations: Jordan's Principle (named for Jordan River Anderson), which makes sure all First Nations children living in Canada can access the products, services and supports they need, when they need them. Joyce's Principle (named for Joyce Echaquan), which aims to guarantee all Indigenous Peoples the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health.

Recommendation: That guidance be developed to establish and promote access to equitable and culturally- and identity-affirming youth-partnered care

Organization(s): Federation of Integrated Youth Services Networks; Foundry; Youth Wellness Hubs Ontario; Aire Ouverte; ACCESS Open Minds; Huddle Manitoba; Health Standards Organization, Canadian Institutes of Health Research; Knowledge Institute on Child and Youth Mental Health and Addictions; CSA Group; Graham Boeckh Foundation; We Matter; Canadian Roots Exchange.

Issue 18 - Systematic Screening Processes and Tools for Youth

Effective screening processes and tools can help ensure children and youth are able to access mental health care and/or substance use health care that meets their needs in a timely fashion by connecting them directly to the required level of care based on their health situation and responds to their desired health outcomes. Screening processes and tools shall prioritize a partnership with the child or young person and seek to provide early intervention and access to care (if needed) before health crises emerge as much as possible. These processes and tools shall be co-designed, work to counter the stigma around discussions of MHSUH (including personal stigma, social stigma, and structural stigma), take a stepped-care[10] approach that connects people directly to the supports they require in a timely fashion (including concurrent care for those who require it), and ensure that "no door is the wrong door" in accessing services. Ongoing investments in the system are required to ensure there are sufficient care providers, and those providers shall be equipped with the knowledge, resources, and support to ensure they have technical and behavioural competencies to confidently provide MHSUH care to young people.

When systematic screening processes and tools are implemented, children and young people (and their family and caregivers, as needed) shall be supported through the process with knowledge translation and the services of care navigators, peer support, or other similar services. Conversations about care shall be trauma-informed, and support for family and caregivers is also required to ensure their health is safeguarded as well. Where needed, interpretation services (including sign language, when necessary) shall be available for individuals who have limited English/French language skills, have limited verbal capacity, or are nonverbal.

Processes and tools must account for the acuity and urgency of needs for the children and young people so that the necessary level of care is provided as soon as it is needed. In circumstances where waiting

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[10] Stepped care, when used within this document, refers to a model of care that recognizes that individuals have unique care needs and that they should have access to the care they need when they need it.

lists prevent immediate access to care, additional care options shall be provided to ensure the individual is receiving some level of support while on a waiting list. Harm reduction should be explored, where appropriate. For individuals receiving care, any transitions between care providers need to be smooth and avoid (as much as possible) requiring them to retell their stories repeatedly. Screening processes and tools shall also avoid unnecessary administrative burdens, such as excessive forms or paperwork that are not needed or were previously completed. Communication and data sharing between providers must respect data privacy, security, and sovereignty, including Indigenous data sovereignty.

Since standardized processes and tools may not always meet the needs of historically underserved communities, special attention needs to be given to the circumstances of each individual young person. Processes and tools shall be evidence-based and evidence-generating, ensuring that any shortcomings can be recognized and addressed. They shall address and remove stigma and be based on antiracist principles. Additional consideration shall be made to ensure that young people affected by the corrections system (including the children of people who are incarcerated) are well-served by these tools—and treatments shall not be compromised by correctional approaches. Social determinants of health shall factor into the screening processes as well. Follow-up care must also be provided, to help measure the effectiveness of any interventions and ensure the young person has the necessary support for their journey to improved health.

Distinct but linked Key Issues:

- Working Group 1: Accountability and Evaluation Mechanisms
- Working Group 1: Harm Reduction as a Core Principle or Approach
- Working Group 1: Quality of Health Achievable through Effective Management of Social Determinants of Health
- Working Group 2: Timely Access to MHSUH Care
- Working Group 2: Continuum of Care
- Working Group 4: Collaborative approach for assessment, treatment, and support planning

Gap: Developing and Implementing Systematic Screening Processes and Tools for Youth. Effective screening processes and tools can help ensure children and youth are able to access mental health care and/or substance use health care that meets their needs in a timely fashion by connecting them directly to the required level of care based on their health situation and responds to their desired health outcomes. Screening processes and tools shall prioritize a partnership with the child or young person and seek to provide early intervention and access to care (if needed) before health crises emerge as much as possible.

Regulatory Considerations: First Nations Principles of OCAP (Ownership, Control, Access, and Possession) related to health data (see: First Nations Information Governance Centre, FNIGC.ca)

Recommendation: That guidance be developed to outline how to develop systematic screening processes and tools that prioritize youth agency and help children and youth access the mental health and/or substance use health care they need in a timely manner.

Organization(s): Federation of Integrated Youth Services Networks; Foundry; Youth Wellness Hubs Ontario; Aire Ouverte; ACCESS Open Minds; Huddle Manitoba; Health Standards Organization; Canadian Institutes of Health Research; Knowledge Institute on Child and Youth Mental Health and Addictions; CSA Group; Graham Boeckh Foundation; We Matter; Canadian Roots Exchange, International Organization for Standardization.

Issue 19 - Communication and Collaboration Across the Continuum of Care for Children and Youth

Effective communication and collaboration between young people and those around them is important to protect their MHSUH. This collaboration shall extend from the young person to their families (or chosen families) through schools, community organizations (e.g., sports clubs, community centres, religious/cultural centres), and across the continuum of care[11] for young people. This collaborative model of support and care shall focus on meeting young people where they are, partnering with young people, removing stigma and shame, early intervention, harm reduction, stepped care, affirming a young person's identity and culture, and supporting them in pursuing their self-identified health goals. Communication and data sharing between providers must always respect ongoing consent, data privacy, security, and sovereignty, including Indigenous data sovereignty.

Education facilities (including early childhood centres, daycare centres, primary school, secondary schools, and post-secondary institutions) present an early opportunity to educate students about MHSUH and engage them in their own well-being. Education, health promotion, prevention, and early intervention strategies within schools, in collaborative partnership with community and/or health organizations, can help give young people a fuller understanding of MHSUH. These institutions can also facilitate access to care for young people who have questions, concerns, or issues related to MHSUH (or that of loved ones). For young people seeking or receiving care, schools shall provide support, flexibility, and empathy. The information or documentation required of students to explain absences need to be reasonable and not invasive or retraumatizing; health care navigators, practitioners, and family/chosen family/trusted adults may be able to help young people explain absences or missed assignments to school administrators. In Canada, the capacity of schools to support students in this way can be hampered by resourcing constraints, and further investment in this area could provide better support for the health of young people.

Those providing support and care for the MHSUH of young people shall communicate and collaborate with others involved in a young person's life, while also respecting the young person's agency and ongoing informed consent. Communication and collaboration with families, chosen families, and trusted adults can help young people make informed decisions on their health, and care providers need to prioritize helping a young person in assembling a personal support system that will enable them to pursue their personal health goals.

Effective screening processes are important, particularly given the frequent co-occurrence of MHSUH issues; care providers seeing young people for issues in one of those areas need to screen for unrecognized co-occurring issues in the other area. There may be a need to develop new or complementary youth-friendly behavioural and technical competencies so that care providers are equipped with the tools and techniques needed to provide effective care to young people. Follow-up care is important, including during transitions of care, to ensure that collaboration between care providers is ongoing and that young people continue to receive the support and care they need. Approaches to care shall be evidence-informed and evidence-generating and shall be appropriate for the developmental stage and capacity of the young person.

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[11] The "continuum of care" refers to the connected (and sometimes disconnected) segments of the health care system, from education and preventive care, early intervention, treatments or other interventions, rehabilitation, maintenance, and discharge from care. This continuum is not always linear, and individuals may move back and forth along this continuum during their health care journeys.

Effective communication and collaboration are particularly important to ensure there are no gaps in support when young people are going through transitions in care, including discharge from care, reintegration into their communities, administrative transitions between jurisdictions, and age-related transitions. Young people who are nearing a transition toward adulthood may need particular support and care; in some circumstances, it may make more sense for an "adult" to continue receiving care from a provider who primarily cares for young people. Flexibility is important in ensuring an individual receives the right level of care. Additionally, given the waitlists that exist for adult-oriented care, it may make sense for a young person to be placed on a waitlist for care before they are technically eligible; their wait time will then be reduced once they are eligible to access that adult-oriented care. Transitions between one jurisdiction to another (i.e., between countries, provinces, or care providers); can also be challenging; bridgers, navigators, and similar supports can help young people navigate transitions in care.

Special consideration shall be made for young people who are or have been involved with the corrections system. Punitive approaches shall be replaced by supportive approaches, where possible, and it is important to ensure that interventions do not (intentionally or unintentionally) put young people at increased risk of experiencing homelessness or human trafficking. It is similarly important to recognize the social determinants of health, and that a young person's basic needs (food, safe housing, personal security) need to be met before they will be able to effectively pursue a healthy life.

Distinct but linked Key Issues:

- Working Group 1: Accountability and Evaluation Mechanisms
- Working Group 1: Harm Reduction as a Core Principle or Approach
- Working Group 1: Quality of Health Achievable through Effective Management of Social Determinants of Health
- Working Group 1: Coordinated Access and Accessibility
- Working Group 2: Timely Access to MHSUH Care
- Working Group 2: Continuum of Care
- Working Group 2: Mobile Crisis Response/Mobile Crisis Care
- Working Group 4: Continuum of Care (Special Considerations for Complex Needs)
- Working Group 4: Collaborative Approach for Assessment, Treatment, and Support Planning

Gap: Communication and Collaboration Across the Continuum of Care for Children and Youth. To ensure the MHSUH of young people is protected, it is imperative that the people and organizations responsible for their well-being communicate and collaborate effectively. This collaboration shall extend from families through schools, community organizations (e.g., sports clubs, community centres, religious/cultural centres), and across the continuum of care for young people.

Recommendation: That guidance be developed to facilitate communication and collaboration between young people, families/chosen families, community organizations, and the continuum of care in improving or preserving the MHSUH of young people.

Organization(s): Federation of Integrated Youth Services Networks; Foundry; Youth Wellness Hubs Ontario; Aire Ouverte; ACCESS Open Minds; Huddle Manitoba; Health Standards Organization; Canadian Institutes of Health Research; Knowledge Institute on Child and Youth Mental Health and Addictions; CSA Group; Graham Boeckh Foundation; We Matter; Canadian Roots Exchange; Centre for Addictions and Mental Health, International Organization for Standardization.

Issue 20 - Substance Use Health Care for Young People

Young people seeking substance use health care require support that considers their developmental stage in life. As outlined in the United Nations Convention on the Rights of the Child[12], to which Canada is signatory, we have a duty to protect young people from harmful drugs and psychotropic substances, and from the harms associated with the drug trade.

Discussions of the substance use health of children and youth shall prioritize education, early intervention (screening, brief intervention, and referral to treatment), and evidence-based harm reduction, and there is a need to build capacity in all these areas to reduce and address substance use health issues in young people. Parents and caring adults in the community (including those in community youth organizations, clubs and sports teams, and integrated service hubs) can support young people through education and early intervention but may require more well-developed training and resources to effectively do so in a way that supports and resonates with young people. These relationships can help young people contribute to their communities, find meaning in those connections, and instill hope for their health and wellbeing.

Substance use health care shall meet young people where they are, partner with them in selecting care and interventions, be strengths-based, affirm their culture and identity, be trauma-informed, require ongoing consent, and seek to remove stigma and shame from discussions. A stepped-care approach can help ensure the right level of care is provided, and care providers need to be equipped with the knowledge, resources, and support to ensure they have technical and behavioural competencies to confidently provide substance use health care to young people. Family, chosen family, and caring adults are often important partners for young people seeking substance use health care, and need to be supported in this role. Abstinence-based approaches do not work for all individuals and present a barrier to access to care; young people need to be able to access care even (perhaps especially) when they are experiencing symptoms of their illness(es) related to substance use health or mental health. Young people shall not be refused care because they have used substances.

The frequent co-occurrence of MHSUH issues must be recognized and addressed. Young people with mental health issues may attempt to seek relief through the harmful use of substances, and substance use can also lead to mental health issues. When a young person seeks support for either of these issues, screening needs to take place to ensure that the care they receive addresses their full selves, in an integrated way that considers mental health, substance use health, and physical health.

Incarceration, the corrections system, and the child welfare system are generally ill-suited to supporting young people with substance use health issues. Young people affected by the corrections system, including those who are incarcerated, shall have access to evidence-based and supportive substance use health care to support their journey toward better health. It is similarly important to recognize the social determinants of health, and that a young person's basic needs (food, safe housing, personal security) need to be met before they will be able to effectively pursue a healthy life.

Distinct but linked Key Issues:

- Working Group 1: Harm Reduction as a Core Principle or Approach
- Working Group 1: Coordinated Access and Accessibility
- Working Group 2: Timely Access to MHSUH Care
- Working Group 2: Continuum of Care
- Working Group 4: Harm Reduction (Special Considerations for Complex Needs)

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[12] https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child

Gap: Substance Use Health Care for Young People. Young people seeking substance use health care require support that considers their developmental stage in life. Discussions of the substance use health of children and youth shall prioritize education, early intervention, and evidence-based harm reduction. Care shall meet young people where they are, partner with them in selecting care and interventions, affirm their culture and identity, be trauma-informed, and seek to remove stigma and shame from discussions. **Is R&D Needed?** Yes. Further research is required to determine which key areas require prioritizing to create the foundation for data collaboration.

Recommendation: That guidance be developed to outline effective strategies to support the substance use health of young people through education, early intervention, and evidence-based harm reduction.

Organization(s): Federation of Integrated Youth Services Networks; Foundry; Youth Wellness Hubs Ontario; Aire Ouverte; ACCESS Open Minds; Huddle Manitoba; Health Standards Organization; Canadian Institutes of Health Research; Knowledge Institute on Child and Youth Mental Health and Addictions; CSA Group; Graham Boeckh Foundation; We Matter; Canadian Roots Exchange; Centre for Addictions and Mental Health; Canadian Centre for Substance Use and Addictions.

Issue 21 - Support for Caregivers Who Support Young People

Family, chosen family, and caregivers often form a vital support system for young people seeking care for mental health and/or substance use health challenges. To effectively support young people, though, these individuals must be equipped with the information, resources, and time necessary to help young people identify and pursue the care they need.

In keeping with a youth-partnered approach, young people shall provide ongoing consent to the involvement of family, chosen family, or other caring adults in discussions of their health and care decisions. This must also be informed by a young person’s individual circumstances, including their capacity to make an informed choice. Support can also often be found in a young person’s community, including school systems. It is important to note that parents are not always supportive of the identity or care decisions made by young people; respect needs to be given to the role of parents and caregivers, but the consent of the young person should be centred in these discussions.

Supportive adults need accessible information, resources, and time necessary to work with young people in ensuring there is a clear understanding of health care options and meaningful consent toward the chosen options. Knowledge translation may be necessary to ensure understanding; a health care navigator may help in this regard. It is also important that consideration be given to an individual’s first language, and interpretation services need to be made available (including for individuals who are nonverbal or minimally verbal). This information must also be culturally relevant to ensure it meets the need of the young person seeking care.

Supports shall also emphasize the importance of eliminating stigma around MHSUH, affirming intersectional identities of young people, cultural safety, and antiracism.

Distinct but linked Key Issues:

- Working Group 1: Privacy and Confidentiality in MHSUH
- Working Group 4: Valuing the role of families/caregivers in supporting people with complex needs, acknowledging their own needs for services/supports

Gap: Support for Caregivers Who Support Young People. Family, chosen family, caregivers, and caring adults often form a vital support system for young people seeking care for mental health and/or substance use health challenges. To effectively support young people, though, these individuals must be equipped with the information, resources, and time necessary to help young people identify and pursue the care they need.

Recommendation That tools be developed to provide necessary resources and support for caring adults (family, chosen family, other meaningful adults) who support the health and wellbeing of young people.

Organization(s): Federation of Integrated Youth Services Networks; Foundry; Youth Wellness Hubs Ontario; Aire Ouverte; ACCESS Open Minds; Huddle Manitoba; Health Standards Organization; Canadian Institutes of Health Research; Knowledge Institute on Child and Youth Mental Health and Addictions; CSA Group; Graham Boeckh Foundation; We Matter; Canadian Roots Exchange; Centre for Addictions and Mental Health.

Working Group 4: People with Complex Needs

Issue 22 - Person-Centred Healthcare and Co-creation of Care

Person-centred, trauma-informed care is at the core of delivering effective health care, and it is particularly crucial for individuals with complex needs. This approach requires recognizing and prioritizing the unique goals and preferences of individuals seeking care, and often involves their families and caregivers. Care should consider not just physical health, but also mental health, substance use health, recognize and address social vulnerabilities and other life challenges.

Person-centred care recognizes people with complex needs as unique individuals, tailoring treatment plans to their distinct requirements. The healthcare team shoulders the responsibility of collaborating and integrating the individual’s physical, mental, and social well-being into their healthcare plan, ensuring a personalized approach. A top priority is the protection of client’s rights, the promotion of autonomy, and self-determination. When a person lacks the capacity for decision making about health care treatment, then decisions should be supported by individuals trusted by the person seeking care and their service providers.

Implementation of person-centred care will require systemic change, such as pan-Canadian standards, guidance, and policies co-developed with individuals with lived/living expertise and families/caregivers. This would help establish a person-centred culture in clinical settings and support families and caregivers in navigating the challenges associated with complex care. Collective efforts to address social needs and coordinate care across different settings are pivotal in enhancing the effectiveness and inclusivity of person-centred care. By fostering co-creation with individuals, their families, as appropriate, and their care teams, this collaborative model ensures that care is shaped by the unique perspectives and preferences of those directly involved.

Gap: Advancing Person-Centred Care for Individuals with Complex Needs. Acknowledging the paramount importance of person-centred care, especially for individuals with complex needs, underscores the necessity for national standardized guidelines co-led by people with lived and living expertise and family/caregivers. These guidelines would ensure uniform care delivery regardless of service access points. Systemic changes are imperative to cultivate a culture of person-centred care and offer enhanced support for individuals in need.

Recommendation: To effectively implement person-centred care, it is imperative to implement systemic changes, including the development of standards, guidance, and policies collaboratively developed with individuals with lived/living expertise, as well as families and caregivers. This collaborative approach will foster a person-centred culture within clinical settings and provide essential support to families and caregivers as they navigate the complexities of care.

Organization(s): The working group expressed discomfort with listing organizations without obtaining prior permission.

Issue 23 - Valuing the Role of Families/Caregivers in Supporting People with Complex Needs, and Acknowledging their Own Needs for Services/Supports

Families and caregivers of people with complex needs play a central role in navigating the intricacies of the healthcare system. Despite their critical roles as primary caregivers, case managers, and immediate responders, they function independently of the health system. However, their involvement is often overlooked, leading to challenges such as suboptimal treatment, strained relationships, and missed holistic support opportunities.

It’s crucial to recognize the emotional, mental, and financial toll on caregivers themselves, as their well-being directly influences the health outcomes of their loved ones. Caregivers in this context refer to individuals providing care without compensation, encompassing both familial ties and non-familial, informal circles of care, such as friends, as determined by the client. It’s crucial to consistently seek permission from individuals regarding family involvement in their care, ensuring that this is an ongoing inquiry, and individuals retain the right to withdraw their permission at a later date. The needs of caregivers and family members evolve across the lifespan, just as people with complex needs have shifting requirements over time. Acknowledging these dynamic shifts and adjusting support mechanisms is essential.

Regulatory barriers, confidentiality dilemmas, and limited access to suitable housing further intensify these challenges. A concerted effort is required to acknowledge and include families and caregivers as essential partners in the care continuum, value their insights, and seamlessly integrate their contributions into MHSUH care for people with complex needs. Balancing the input of families/caregivers while respecting clients’ autonomy and legal capacity can be complex.

Gap: Addressing the Gap in Valuing and Integrating Families/Caregivers as Essential Partners in Supporting People with Complex Needs. While families and caregivers of people with complex needs are pivotal in navigating the healthcare system, there exists a pronounced gap in recognizing, integrating, and comprehensively supporting their role. This oversight results in challenges like suboptimal treatment, strained relationships, and missed holistic support opportunities. The evolving needs of both caregivers and the individuals they support, coupled with the additional challenges of regulatory barriers, confidentiality issues, and housing constraints, further widen this gap. Bridging this divide necessitates a concerted effort to value and seamlessly integrate the contributions of families and caregivers as essential partners in the care continuum.

Regulatory Considerations: The Personal Health Information Protection Act (PHIPA); Health information sharing regulations across jurisdictions; The Health Care Consent Act in Ontario and similar legislation in other provinces outline the rules for obtaining informed consent from clients or their substitute decision-makers for medical treatments and procedures; Mental Health Act: Each territory and province have their own mental health regulations. These govern procedures for substitute decision making, capacity evaluation, Assessments, admissions, and the threshold of when it is medically necessary to provide treatment to a client who is incapable of making their own health care decisions. These Acts set out various levels of involvement for families/caregivers to help clients recover.

Long-Term Care Regulations: Long-term care facilities and services are regulated at the provincial level. Regulations often address issues like the quality of care, resident rights, and family involvement in care planning. For example, the Long-Term Care Homes Act in Ontario sets out guidelines for family councils and the role of families in the care of their loved ones.

Recommendation: The development of robust standards is imperative to bridge the gap identified in "Valuing the Role of Families/Caregivers in Supporting People with Complex Needs." To address the evolving needs of both caregivers and people with complex needs across the lifespan, it is recommended to establish national standards that emphasize the significance of families/caregivers. These standards should articulate how healthcare providers can effectively engage caregivers and support networks in care planning, decision-making, and treatment processes while upholding clients' autonomy.

To enhance these standards, consider several key aspects. Firstly, given the difficulties families face due to variations in how the Mental Health Act is interpreted, it is recommended to establish a formal process for reviewing provincial acts with a clear vision and the aim of achieving standardization. While there are similarities among the 13 jurisdictions, nuanced differences in each province's laws make it challenging for parents to navigate healthcare systems.[13] Collaborative efforts and uniformity in legal and regulatory requirements will assist parents in navigating healthcare processes effectively.

Secondly, a key aspect of these standards should involve recognizing the changing requirements of caregivers and people with complex needs at various life stages. This may require the creation of adaptable support models that can be customized to address specific circumstances and challenges encountered by both caregivers and those under their care.

Thirdly, to ensure successful implementation, it is advisable to introduce targeted training programs for healthcare professionals. These programs can enhance professionals' comprehension of the pivotal

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[13] This falls directly under the jurisdiction of Provincial/Territorial authorities, as they hold the responsibility for overseeing and implementing mental health legislation within their respective regions.

role of caregiver involvement and offer practical strategies to effectively engage support networks. This initiative can foster a culture of collaboration and partnership between healthcare providers, support networks, and caregivers, ultimately contributing to more holistic and effective care. Additionally, training programs should include guidance on navigating privacy and confidentiality laws to ensure that they do not hinder care.

Lastly, it is essential to integrate cultural competency training and considerations into the standards. Acknowledging the diverse backgrounds of caregivers and people with complex needs, the standards should advocate for tailored approaches that respect cultural sensitivities and promote inclusive care practices.

To conclude, the establishment of comprehensive national standards that prioritize the role of families and caregivers in supporting individuals with complex needs is a vital step towards more inclusive, person-centred, and effective MHSUH care. By addressing the challenges related to legislative variations, recognizing the evolving needs of caregivers, providing targeted training for healthcare professionals, and promoting cultural competency, these standards can significantly enhance the quality of care delivered across the country. Through collaboration and a shared commitment to the well-being of individuals and their support networks, we can build a more supportive and responsive healthcare system for all Canadians.

Organization(s): Families for Addiction Recovery, Mental Illness Caregivers Association; The Ontario Caregiver Organization; The Canadian Alliance on Mental Illness and Mental Health; The Canadian Centre for Caregiving Excellence; Ontario Family Caregivers' Advisory Network; The Mental Health Commission of Canada; Community Addictions Peer Support Association; Canadian Centre on Substance Use and Addiction.

Issue 24 - Continuum of Care for Complex Needs

The term “continuum of care” describes how health care is provided to a person over time, including (but not limited to) education, health promotion, prevention, early intervention, public health, primary care, acute care, treatment, aftercare, community support and taking into consideration social determinants of health. Better integration along this continuum can help ensure that people with complex health needs receive seamless care that considers their whole person. Every person’s pathway through the continuum of care may look different. The components can overlap and are most effective when used together. Some people may use all services in the continuum of care, whereas others might not. There are also people who might revisit different components as needed. This emphasizes the diverse and individualized nature of the care journey within the continuum.

Presently, gaps exist along this continuum, and those gaps can result in people not receiving the care they need. This is particularly true for people with complex needs. Taking a stepped care approach—namely, offering an individual the most appropriate, effective, yet least resource intensive service, based on the stepped care approach, that will meet their needs and preferences—can help ensure people receive the care they need when they need it. Care must be informed by individual circumstances, including an individual’s capacity to make an informed choice. It is important and beneficial that consideration be given to an individual’s family, chosen family, supporters- and/or caregivers and the role that they could play in health decisions, pending the approval of the person receiving care.

A system aimed at minimizing the time a person must spend in clinical facilities can be achieved through health promotion, harm reduction, and stepped care approaches. This can help avoid health crises that result in hospital visits and extended stays in hospital or clinical facilities.

It is important that services across the continuum of care, including treatment and harm reduction, focus on improving health, and helping people avoid homelessness, the justice and correctional system, and the child welfare system so they can freely pursue their self-identified health goals.

Gap: Comprehensive Assessment of Gaps. The lack of national standards regarding the continuum of care for MHSUH care reveals significant gaps in service provision. While known issues such as access barriers and communication challenges among providers are evident, the Collaborative did not have enough time to comprehensively identify all gaps. These unidentified gaps hinder access to essential care, leading to fragmented services and disparities in delivery. Further assessment is imperative to uncover and address these gaps, promoting a more cohesive and effective care delivery for those in need and for the development of future standards.

Recommendation: Conduct a thorough assessment to identify specific gaps along the continuum of care, including barriers to access, fragmentation of services, and disparities in care delivery. This assessment should be co-led by individuals with lived and living expertise and families/caregivers, in collaboration with healthcare professionals. By empowering individuals with lived and living expertise and families/caregivers to take on leadership roles in the assessment process, their perspectives, needs, and preferences can be prioritized and centred. This collaborative approach ensures that the assessment is conducted with a deep understanding of the challenges faced by those directly impacted, leading to more meaningful insights and effective solutions.

Organization(s): The working group expressed discomfort with listing organizations without obtaining prior permission.

Annex B

List of Tier 1 Published Standards and Related Materials for Key Issues

WORKING GROUP 1: FOUNDATION AND INTEGRATION

Issue 1- Stigma Free and Consensus-based Terminology and Language

ISEN	English Title	Publisher
CSA B701-17	Carer-inclusive and accommodating organizations - First Edition	CSA
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
CAN/HSO 22004	Mental Health and Addictions Services	HSO
N/A	Overcoming Stigma Through Language – A Primer	CCSA-CAPSA
N/A	Stigma Primer for Journalists – A Guide to Better Reporting on Substance Use and the People It Impacts	CCSA-CAPSA
N/A	Hoʻi Hou Ka Mauli Ola: Pathways to Native Hawaiian Health	University of Hawaii Press
N/A	Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada	AFN, NNAPF and Health Canada
N/A	Mauli ola: Pathways to optimal Kanaka Oiwi health	University of Hawaii Press
N/A	Language Matters	MHCC
N/A	Stigma and Discrimination and Mental Health	Mental Health Australia
N/A	Stigma: The Hidden Killer: Background Paper and Literature Review	Mood Disorders Society of Canada
N/A	The Impact of Stigma and Avoiding Stigmatizing Language	Canadian Drug Policy Coalition
N/A	Key terms and definitions in mental health	WHO

Issue 2- Different Types of Evidence and Experiences

ISEN	English Title	Publisher
CGSB CAN/CGSB-191.1-2013	Research ethics oversight of biomedical clinical trials	CGSB
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
HSO 75000	The British Columbia Cultural Safety and Humility Standard	HSO
N/A	BrainHealth Databank	CAMH

N/A	Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism	Social science & medicine
N/A	Decolonizing health care: Challenges of cultural and epistemic pluralism in medical decision-making with Indigenous communities	Bioethics
N/A	Racial Equity Toolkit	Collective Impact Forum
N/A	Rural and Remote Mental Health in Canada Evidence Brief on Best and Promising Practices	MHCC

Issue 3- Accountability and Evaluation Mechanisms

ISEN	English Title	Publisher
No Tier I standard documents were found in the search of SDO and partner organization documents.		
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
N/A	Collaborative Mental Health Care in Canada: Challenges, Opportunities and New Directions	Canadian Journal of Psychiatry
N/A	Adult Substance Use System of Care Framework a Technical Policy Document to Support Health Systems Planning	Ministry of Health, and Addictions - British Columbia
N/A	Appendix B – Core Services Model a Component of British Columbia’s Substance Use Framework A	Ministry of Health, and Addictions - British Columbia
N/A	Ontario Mental Health and Addictions Provincial Data Set – HL7® FHIR® Implementation Guide Updated	EHealthOntario

Issue 4- Human Rights and Substantive Health Equity

ISEN	English Title	Publisher
No Tier I standard documents were found in the search of SDO and partner organization documents.		
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
N/A	Equality, Dignity And Inclusion: Legislation That Enhances Human Rights For People Living With Mental Illness	CMHA
HSO 75000	The British Columbia Cultural Safety and Humility Standard	HSO
N/A	Canadian Human Rights Act	Parliament of Canada
N/A	Mental health, human rights and legislation Guidance and practice	WHO, UN
N/A	Racial Equity Toolkit	Collective Impact Forum

Issue 5- Harm Reduction Principles and Approaches

ISEN	English Title	Publisher
No Tier I standard documents were found in the search of SDO and partner organization documents.		
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
N/A	Guidelines for the Practice of Peer Support	MHCC
HSO 75000	The British Columbia Cultural Safety and Humility Standard	HSO
N/A	Fact Sheet Indigenous Harm Reduction Principles and Practices	FNHA
N/A	Harm Reduction Framework	Substance Abuse and Mental Health Services Administration
N/A	Policy on Harm Reduction - Indigenous Harm Reduction	FNHA

Issue 6- First Nations, Inuit, and Métis Knowledge Systems and Inherent and Treaty Rights

ISEN	English Title	Publisher
No Tier I standard documents were found in the search of SDO and partner organization documents.		
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
N/A	First-of-its-Kind Cultural Safety & Humility Standard a Significant Milestone in Ending Systemic Racism in British Columbia	FNHA
N/A	Addressing Racism in the Health Care System - A Policy Position and Discussion Paper	Pauktuutit Inuit Women of Canada
N/A	Constitution Act, 1982, Part II, Rights of the Aboriginal Peoples of Canada, Section 35	Parliament of Canada
N/A	Guidance on the Use of Standards for Race-Based and Indigenous Identity Data Collection and Health Reporting in Canada	CIHI
N/A	United Nations Declaration on the Rights of Indigenous Peoples	United Nations

Issue 7- Privacy and Confidentiality Related to Mental Health and Substance Use Health

ISEN	English Title	Publisher
No Tier I standard documents were found in the search of SDO and partner organization documents.		
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		

N/A	A Guide to the Personal Health Information Protection Act	Information and Privacy Commissioner
N/A	First Nations Privacy and Modern Health Care Delivery	Indigenous Law Journal
N/A	Freedom of Information and Protection of Privacy Act	BC Law
N/A	Information Sharing in the Context of Mental Health and Substance Use in British Columbia	CMHA
N/A	Personal Health Information Protection Act (PHIPA)	Government of Ontario
N/A	Personal Information Protection Act	BC Law

Issue 8- Quality of Health Services Achievable by Effectively Addressing the Social Determinants of Health

ISEN	English Title	Publisher
No Tier I standard documents were found in the search of SDO and partner organization documents.		
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
N/A	Convention on the Rights of Persons with Disabilities - First Report of Canada	Canadian Heritage
N/A	Convention On The Rights Of Persons With Disabilities (CRPD)	United Nations
N/A	Inuit Nunangat Policy - Final Draft Without Prejudice Inuit Nunangat Policy	Inuit Tapiriit Kanatami
N/A	Letter to Prime Minister Justin Trudeau Regarding NunatuKavut	Inuit Tapiriit Kanatami

Issue 9- Workforce Health, Trainings and Competencies

ISEN	English Title	Publisher
CAN/HSO 11013	Cannabis Use for Medical Purposes: Inpatient Care Settings	HSO
CSA Z1650-21	Paramedic response to the opioid crisis: Education and training across the treatment and care continuum in out-of-hospital and community settings - first edition	CSA
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
N/A	Canadian Guidelines on Prevention, Assessment and Treatment of Depression Among Older Adults	Canadian Coalition for Senior's Mental Health
N/A	Competencies for Canada's Substance Abuse Workforce Section IX Technical Competencies Guide to Working with First Nations Clients	CCSA, NNAPF
N/A	Handbook of Person-Centered Mental Health Care	Hogrefe
N/A	Mental illness and suicide among physicians	The Lancet

N/A	Regulatory Standards for the Mental Health and Substance Use Health Workforce across Canada: Modernizing Regulation to Increase Equitable Access to Services	Athabasca University
N/A	Technical competencies for Canada's substance use and mental health workforce	CCSA

Issue 10- Continuity and Transition of Care

ISEN	English Title	Publisher
BSI PAS 1616	Healthcare – Provision of clinical services – Specification	BSI
ISO 13972	Health informatics — Clinical information models — Characteristics, structures and requirements - First Edition	ISO, AENOR; DIN; SNV; BSI
ISO TS 17975	Health informatics — Principles and data requirements for consent in the collection, use or disclosure of personal health information - Second Edition	ISO; BSI
ISO TS 21089	Health informatics - Trusted end-to-end information flows - First Edition	ISO; BSI
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
N/A	Adopting a Common Approach to Transitional Care Planning: Helping Health Links Improve Transitions and Coordination of Care	HQO
N/A	Continuity of Care as Experienced by Mental Health Service Users - A Qualitative Study	BMC Health Services Research
N/A	Family Caregivers Briefcase for Psychologists	APA
N/A	Implementation of guidelines on family involvement for persons with psychotic disorders in community mental health centres	BMC Health Services Research
N/A	National Guidelines for a Comprehensive Service System to Support Family Caregivers of Adults with Mental Health Problems and Illnesses	MHCC
N/A	Placemat for Supporting High-Quality Transitions Between Hospital and Home for Alternate Level of Care Patients with a Dual Diagnosis	Ontario Health
N/A	Quality Standards - Process and Methods Guide	HQO
N/A	The role of relatives in pathways to care of patients with a first episode of psychosis	International Journal of Social Psychiatry
N/A	Transitional Care Programs for Older Adults: Improving Canada's Core Health Services	Research Outreach
N/A	Transitions Between Hospital and Home - Care for People of All Ages	HQO
N/A	Transitions of Care Standards - a New Way Forward	American Case Management Association, Pfizer
N/A	Transitions of Care: Technical Series on Safer Primary Care	WHO

WORKING GROUP 2: PRIMARY HEALTH SERVICES INTEGRATION

Issue 11- Timely Access to Mental Health and Substance Use Health Care

ISEN	English Title	Publisher
TBD	Workshop Agreement - Integrating Mental Health and Substance Use Health with Primary Care in Canada	CSA
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
CAN/DGSI 100-5	Health data and information capability framework	DGC
CAN/DGSI 103-2	Digital Trust and Identity - Part 2: Delivery of healthcare services	DGC
CAN/HSO 11012	Access to Health and Social Services in Official Languages	HSO
CAN/HSO 22004	Mental Health and Addictions Services	HSO
CAN/HSO 3001	Medication Management	HSO
CAN/HSO 34014	Medication Management for Community-Based Organizations	HSO
CAN/HSO 5064	Suicide Prevention Program	HSO
CAN/HSO 76000	Integrated People-Centred Health Systems	HSO
CAN/HSO 83001	Virtual Health	HSO
CIOSC/PAS 100-6	Data governance - Part 6: Responsible collection and use of digital contact tracing and monitoring data in the workplace	DGC
HSO 34015	Primary Health Care Services	HSO
HSO 75000	Cultural Safety and Humility	HSO

Issue 12- Continuum of Care

ISEN	English Title	Publisher
EN 15224	Quality management systems – EN ISO 9001:2015 for healthcare	DIN; AENOR; BSI; CEN; DANSK; SNV
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
N/A	Improving collaboration between primary care and mental health services	The Wolrd Journal of Biological Psychiatry
CAN/HSO 11012	Access to Health and Social Services in Official Languages	HSO
CAN/HSO 22004	Mental Health and Addictions Services	HSO
CAN/HSO 3001	Medication Management	HSO
CAN/HSO 34014	Medication Management for Community-Based Organizations	HSO
CAN/HSO 5064	Suicide Prevention Program	HSO
CAN/HSO 76000	Integrated People-Centred Health Systems	HSO
CAN/HSO 83001	Virtual Health	HSO

CSA CAN/CSA-ISO IWA 18:17	Framework for integrated community-based life-long health and care services in aged societies - First Edition	CSA
TBD	Workshop Agreement - Integrating Mental Health and Substance Use Health with Primary Care in Canada	CSA
HSO 34015	Primary Health Care Services	HSO
HSO 75000	British Columbia Cultural Safety and Humility Standard	HSO
N/A	Collaboration between mental health and primary care services: A planning and implementation toolkit for health care providers and planners	CCMHI
N/A	Preventive care recommendations to promote health equity	Canadian Medical Association Journal

Issue 13- Quality Assurance for Digital MHSUH Applications

ISEN	English Title	Publisher
TBD	Bridging the Gap: A Comprehensive Review and Public Consultation on what is needed to ensure the Quality, Safety, Transparency, and Effectiveness of Apps for Mental Health and Substance Use Health	HRI
IEC 82304-1	Health software – Part 1: General requirements for product safety	IEC; DANSK
ISO 10781	Health informatics — HL7 Electronic Health Record-System Functional Model, Release 2.1 (EHR FM) - First Edition	ISO; CEN
ISO 12967-1	Health informatics — Service architecture (HISA) — Part 1: Enterprise viewpoint - Second Edition	ISO; SNV
ISO 13131	Health informatics — Telehealth services — Quality planning guidelines - First edition	ISO
ISO 13606-4	Health informatics — Electronic health record communication — Part 4: Security - First edition	ISO; SNV
ISO 22600-1	Health informatics - Privilege management and access control - Part 1: Overview and policy management - First Edition	ISO; NEN
ISO 22600-2	Health informatics - Privilege management and access control - Part 2: Formal models - First Edition	ISO; DIN; EN
ISO 22600-3	Health informatics - Privilege management and access control - Part 3: Implementations - First Edition	ISO; SNV
ISO 22857	Health informatics - Guidelines on data protection to facilitate trans-border flows of personal health data - Second Edition	ISO
ISO TR 11147	Health informatics — Personalized digital health — Digital therapeutics health software systems - First Edition	ISO; BSI; EN
ISO TR 18638	Health informatics - Guidance on health information privacy education in healthcare organizations - First Edition	ISO; BSI
ISO TR 20055	Health informatics – Person owned document repository for PHR applications and health information exchange - First Edition	ISO; BSI; DANSK
ISO TR 21835	Health informatics — Personal health data generated on a daily basis - First edition	ISO; DANSK
ISO TR 22696	Health informatics — Guidance on the identification and authentication of connectable Personal Healthcare Devices (PHDs) - First edition	ISO; DANSK

ISO TS 14441	Health informatics - Security and privacy requirements of EHR systems for use in conformity assessment - First Edition	ISO; CEN
ISO TS 23535	Health informatics — Requirements for customer-oriented health cloud service agreements - First edition	ISO
ISO TS 82304-2	Health software — Part 2: Health and wellness apps — Quality and reliability - First edition	ISO; AENOR; BSI; DANSK
ISO/TS 17975	Health informatics – Principles and data requirements for consent in the collection, use or disclosure of personal health information	DANSK; BSI
ITU-T F.780.2	Accessibility of telehealth services - Version 2; Study Group 16	ITU-T
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
CAN/DGSI 100-5	Health data and information capability framework	DGC
CAN/DGSI 103-2	Digital Trust and Identity - Part 2: Delivery of healthcare services	DGC
CAN/HSO 1003	Clinical Governance Standard	HSO
CAN/HSO 11012	Access to Health and Social Services in Official Languages	HSO
CAN/HSO 83001	Virtual Health	HSO
CIOSC/PAS 100-6	Data governance - Part 6: Responsible collection and use of digital contact tracing and monitoring data in the workplace	DGC
N/A	Digital Health Assessment Technology	ORCHA
N/A	Gap Analysis and Recommendations Report on Digital MHSUH Apps	HRI
N/A	Mental Health App Assessment Framework	MHCC
N/A	Selecting digital health technologies for validation and piloting by healthcare providers: A decision-making perspective from Ontario	International Journal of Technology Assessment in Health Care

Issue 14- Behavioural and Technical Competencies and Workforce Development

ISEN	English Title	Publisher
No Tier I standard documents were found in the search of SDO and partner organization documents.		
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
CAN/HSO 11012	Access to Health and Social Services in Official Languages	HSO
CAN/HSO 22004	Mental Health and Addictions Services	HSO
CAN/HSO 34014	Medication Management for Community-Based Organizations	HSO
CAN/HSO 5064	Suicide Prevention Program	HSO
CAN/HSO 76000	Integrated People-Centred Health Systems	HSO
CAN/HSO 83001	Virtual Health	HSO

TBD	Publicly Available Specification - Substance Use Health Competencies for All Prescribers	CCSA
CSA CAN/CSA-ISO IWA 18:17	Framework for integrated community-based life-long health and care services in aged societies - First Edition	CSA
TBD	Workshop Agreement: Integrating Mental Health and Substance use Health with Primary Care in Canada	CSA
CSA Z1650:21	Paramedic response to the opioid crisis: Education and training across the treatment and care continuum in out-of hospital and community settings	CSA
HSO 34015	Primary Health Care Services	HSO
HSO 75000	Cultural Safety and Humility	HSO
N/A	Developing an Addictions Nursing Competency Framework Within a Canadian Context	Journal of Addictions Nursing
N/A	Enhancing Concurrent Capability (ECC) Toolkit	Alberta Health Services
N/A	Exploring core competencies for mental health and addictions work within a Family Health Team setting	Mental health in family medicine
N/A	Suicide Prevention in Occupational Therapy	CAOT
N/A	The Competence Framework for Mental Health Peer Support Workers	Royal College of Psychiatrists
N/A	Workforce Competencies	CCSA
N/A	Workforce Development	CCSA

Issue 15- Mobile Crisis Response/Mobile Crisis Care

ISEN	**English Title**	**Publisher**
No Tier I standard documents were found in the search of SDO and partner organization documents.		
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
CAN/HSO 11012	Access to Health and Social Services in Official Languages	HSO
CAN/HSO 22004	Mental Health and Addictions Services	HSO
CAN/HSO 34014	Medication Management for Community-Based Organizations	HSO
CAN/HSO 5064	Suicide Prevention Program	HSO
CAN/HSO 76000	Integrated People-Centred Health Systems	HSO
CSA CAN/CSA-ISO IWA 18:17	Framework for integrated community-based life-long health and care services in aged societies - First Edition	CSA
CSA Z1650:21	Paramedic response to the opioid crisis: Education and training across the treatment and care continuum in out-of hospital and community settings	CSA
HSO 34015	Primary Health Care Services	HSO
HSO 75000	Cultural Safety and Humility	HSO
N/A	Developing Mobile Crisis Response Teams: A framework for Ontario	Ontario Provincial Human Services and Justice Coordinating

		Committee (HSJCC)
N/A	Tools for Developing Mobile Crisis Response Teams in Ontario: A complementary guide to support the implementation of Developing Mobile Crisis Response Teams: A framework for Ontario	Ontario Provincial Human Services and Justice Coordinating Committee (HSJCC)

WORKING GROUP 3: CHILDREN AND YOUTH

Issue 16- Youth-Partnered Care

ISEN	English Title	Publisher
SNZ NZS 8156	Ambulance, paramedicine, and patient transfer services	SNZ
TBD	Pan-Canadian Guidance for Integrated Youth Services	Foundry
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
N/A	Forging the Path Forward: A Foundry Service Model Guide	Foundy
N/A	Ten Principles for Integrated Youth Services (IYS)	Foundy
CAN/HSO 76000	Integrated People-Centred Health Systems	HSO
CSA Z2003:20	Mental health and well-being for post-secondary students	CSA
HSO 82001	Child, Youth and Family Services	HSO
N/A	Canada’s Guidance on Alcohol and Health	CCSA
N/A	Overcoming Stigma Through Language – A Primer	CCSA/CAPSA
N/A	Comprehensive resource documents for Integrated Youth Services	Federation of Integrated Youth Services Networks
N/A	Depression in children and young people: identification and management	National Institute for Health and Care Excellence
N/A	Guidance Document on Integrated Youth Services	Foundry/Federation of Integrated Youth Services Networks
N/A	Lower-Risk Cannabis Use Guidelines (LRCUG) for Youth	CAMH
N/A	Preventive care recommendations to promote health equity	Canadian Medical Association Journal
N/A	Quality standard for family engagement	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Quality standard for youth engagement	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Quality Standard on Levels of Care	Knowledge Institute on Child and Youth Mental Health and Addictions

N/A	Youth as Partners, Participants or Passive Recipients: A Review of Children and Adolescents in Community-Based Participatory Research (CBPR)	American journal of community psychology.
PAS/HSO 22005	Youth Mental Health and Addiction Services Publicly Available Specification	HSO

Issue 17- Promoting Access to Equitable and Culturally- and Identity-Affirming Youth-Partnered Care

ISEN	**English Title**	**Publisher**
N/A	Quality guideline for virtual walk-in services	The knowledge Institute on Child and Youth Mental Health and Addictions
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
CAN/HSO 76000	Integrated People-Centred Health Systems	HSO
CSA Z2003:20	Mental health and well-being for post-secondary students	CSA
HSO 75000	The British Columbia Cultural Safety and Humility Standard	HSO
HSO 82001	Child, Youth and Family Services	HSO
N/A	Canada's Guidance on Alcohol and Health	CCSA
N/A	Overcoming Stigma Through Language – A Primer	CCSA/CAPSA
N/A	Comprehensive resource documents for Integrated Youth Services	Federation of Integrated Youth Services Networks
N/A	Guidance Document on Integrated Youth Services	Foundry/Federation of Integrated Youth Services Networks
N/A	Lower-Risk Cannabis Use Guidelines (LRCUG) for Youth	CAMH
N/A	Pan-Canadian Standards for Healthcare Equity: The Case for Provincial Interpretation Services	National Newcomer Navigation Network
N/A	Quality standard for family engagement	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Quality standard for youth engagement	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Quality Standard on Levels of Care	Knowledge Institute on Child and Youth Mental Health and Addictions
PAS/HSO 22005	Youth Mental Health and Addiction Services Publicly Available Specification	HSO

Issue 18- Systematic Screening Processes and Tools for Youth

ISEN	English Title	Publisher
SNZ NZS 8006	Screening, Risk assessment and Intervention for Family Violence including Child abuse and neglect	SNZ
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
CAN/HSO 76000	Integrated People-Centred Health Systems	HSO
CSA Z2003:20	Mental health and well-being for post-secondary students	CSA
HSO 75000	The British Columbia Cultural Safety and Humility Standard	HSO
HSO 82001	Child, Youth and Family Services	HSO
N/A	Canada's Guidance on Alcohol and Health	CCSA
N/A	Overcoming Stigma Through Language – A Primer	CCSA/CAPSA
N/A	Comprehensive resource documents for Integrated Youth Services	Federation of Integrated Youth Services Networks
N/A	Depression in children and young people: identification and management	National Institute for Health and Care Excellence
N/A	Guidance Document on Integrated Youth Services	Foundry/Federation of Integrated Youth Services Networks
N/A	Lower-Risk Cannabis Use Guidelines (LRCUG) for Youth	CAMH
N/A	Pan-Canadian Standards for Healthcare Equity: The Case for Provincial Interpretation Services	National Newcomer Navigation Network
N/A	Preventive care recommendations to promote health equity	Canadian Medical Association Journal
N/A	Quality standard for family engagement	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Quality standard for youth engagement	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Quality Standard on Levels of Care	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Stepped Care 2.0	Stepped Care Solutions
PAS/HSO 22005	Youth Mental Health and Addiction Services Publicly Available Specification	HSO

Issue 19- Communication and Collaboration Across the Continuum of Care for Children and Youth

ISEN	English Title	Publisher
ISO 13972	Health informatics — Clinical information models — Characteristics, structures and requirements - First Edition	ISO; DIN; AENOR; BSI; SNV
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
CAN/HSO 76000	Integrated People-Centred Health Systems	HSO
CSA Z2003:20	Mental health and well-being for post-secondary students	CSA
HSO 75000	The British Columbia Cultural Safety and Humility Standard	HSO
HSO 82001	Child, Youth and Family Services	HSO
N/A	Canada's Guidance on Alcohol and Health	CCSA
N/A	Overcoming Stigma Through Language – A Primer	CCSA/CAPSA
N/A	Comprehensive resource documents for Integrated Youth Services	Federation of Integrated Youth Services Networks
N/A	Depression in children and young people: identification and management	National Institute for Health and Care Excellence
N/A	Guidance Document on Integrated Youth Services	Foundry/Federation of Integrated Youth Services Networks
N/A	Lower-Risk Cannabis Use Guidelines (LRCUG) for Youth	CAMH
N/A	Preventive care recommendations to promote health equity	Canadian Medical Association Journal
N/A	Quality standard for youth engagement	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Quality standard for youth engagement	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Quality Standard on Levels of Care	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Youth as Partners, Participants or Passive Recipients: A Review of Children and Adolescents in Community-Based Participatory Research (CBPR)	American journal of community psychology.
PAS/HSO 22005	Youth Mental Health and Addiction Services Publicly Available Specification	HSO

Issue 20- Substance Use Health Care for Young People

ISEN	English Title	Publisher
No Tier I standard documents were found in the search of SDO and partner organization documents.		
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
N/A	Treatment of Opioid Use Disorder for Youth	British Columbia Centre on Substance Use
CAN/HSO 76000	Integrated People-Centred Health Systems	HSO
CSA Z2003:20	Mental health and well-being for post-secondary students	CSA
HSO 82001	Child, Youth and Family Services	HSO
N/A	Canada's Guidance on Alcohol and Health	CCSA
N/A	Overcoming Stigma Through Language – A Primer	CCSA/CAPSA
N/A	Comprehensive resource documents for Integrated Youth Services	Federation of Integrated Youth Services Networks
N/A	Guidance Document on Integrated Youth Services	Foundry/Federation of Integrated Youth Services Networks
N/A	Parents Like Us: The unofficial survival guide to parenting a young person with a substance use disorder	Foundry
N/A	Preventive care recommendations to promote health equity	Canadian Medical Association Journal
N/A	Quality standard for family engagement	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Quality standard for youth engagement	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Quality Standard on Levels of Care	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Stepped Care 2.0	Stepped Care Solutions
N/A	Youth as Partners, Participants or Passive Recipients: A Review of Children and Adolescents in Community-Based Participatory Research (CBPR)	American journal of community psychology
PAS/HSO 22005	Youth Mental Health and Addiction Services Publicly Available Specification	HSO

Issue 21-Support for Caregivers Who Support Young People

ISEN	English Title	Publisher
No Tier I standard documents were found in the search of SDO and partner organization documents.		
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
CAN/HSO 76000	Integrated People-Centred Health Systems	HSO
CSA Z2003:20	Mental health and well-being for post-secondary students	CSA
HSO 82001	Child, Youth and Family Services	HSO
N/A	Canada's Guidance on Alcohol and Health	CCSA
N/A	Overcoming Stigma Through Language – A Primer	CCSA/CAPSA
N/A	Comprehensive resource documents for Integrated Youth Services	Federation of Integrated Youth Services Networks
N/A	Guidance Document on Integrated Youth Services	Foundry/Federation of Integrated Youth Services Networks
N/A	Lower-Risk Cannabis Use Guidelines (LRCUG) for Youth	CAMH
N/A	Parents Like Us: The unofficial survival guide to parenting a young person with a substance use disorder	Foundry
N/A	Post-Event Report, 2023 International Transitions from Child Protection Symposium	International Transitions from Child Protection Symposium
N/A	Quality standard for family engagement	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Quality standard for youth engagement	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Quality Standard on Levels of Care	Knowledge Institute on Child and Youth Mental Health and Addictions
N/A	Youth as Partners, Participants or Passive Recipients: A Review of Children and Adolescents in Community-Based Participatory Research (CBPR)	American journal of community psychology
PAS/HSO 22005	Youth Mental Health and Addiction Services Publicly Available Specification	HSO

WORKING GROUP 4: PEOPLE WITH COMPLEX NEEDS

Issue 22- Person-Centered Healthcare and Co-creation of Care

ISEN	English Title	Publisher
No Tier I standard documents were found in the search of SDO and partner organization documents.		
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
CAN/HSO 22004	Mental Health and Addictions Services	HSO
N/A	Serious Mental Illness: Person-centered Approaches	Patient-centered Care
N/A	The principles of person-centred care	Bain Injury Canada
N/A	The right of caregivers to access health information of relatives with mental illness	International journal of law and psychiatry
EN17398	Patient involvement in health care - Minimum requirements for person-centred care	AENOR

Issue 23- Valuing the Role of Families/Caregivers in Supporting People with Complex Needs, and Acknowledging their Own Needs for Services/Supports

ISEN	English Title	Publisher
No Tier I standard documents were found in the search of SDO and partner organization documents.		
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
N/A	Engaging Caregivers in Mental Health and Addiction Services in Canada - Promising Practices Guide	MHCC
N/A	National Guidelines for a Comprehensive Service System to Support Family Caregivers of Adults with Mental Health Problems and Illnesses	MHCC
N/A	Supporting Adult Carers	National Institute for Health and Care Excellence

Issue 24- Continuum of Care for people with complex needs

ISEN	English Title	Publisher
No Tier I standard documents were found in the search of SDO and partner organization documents.		
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
N/A	A framework for better, more accessible mental health systems	Stepped Care Solutions

N/A	Best Practices across the Continuum of Care for the Treatment of Opioid Use Disorder	CCSA
N/A	Harm Reduction Principles for Healthcare Settings	Harm Reduction Journal

OVERALL COLLABORATIVE

ISEN	English Title	Publisher
CAN/HSO 11013	Cannabis Use for Medical Purposes: Inpatient Care Settings	HSO
N/A	Preventing violence and harassment in Canadian workplaces	CSA
N/A	Psychological Health and Safety in the Workplace: Employer Practices in Response to COVID-19	CSA
N/A	Social anxiety disorder: recognition, assessment and treatment	National Institute for Health and Care Excellence
N/A	System-Level Standards for Concurrent Disorders	Government of Nova Scotia, Department of Health and Wellness
N/A	Workplace fatigue: Current landscape and future considerations	CSA
N/A	Workplace policies on substance use: Implications for Canada	CSA
OTHER GUIDANCE/DOCUMENTS/STANDARDS PROPOSED BY WORKING GROUP MEMBERS		
TBD	Workshop Agreement for Early Psychosis Intervention	HSO, CAMH
N/A	Guidelines for Recovery-Oriented Practice	MHCC
N/A	Update of Canada's Low-Risk Alcohol Drinking Guidelines: Final Report for Public Consultation	CCSA
N/A	Canadian guideline for the clinical management of high-risk drinking and alcohol use disorder	Canadian Medical Association Journal
N/A	CAOT Position Statement: Occupational Therapy to Prevent and Support Recovery from Suicide	CAOT

Annex C

SCC CCN

INDIGENOUS ENGAGEMENT ON THE NATIONAL MENTAL HEALTH AND SUBSTANCE USE HEALTH STANDARDIZATION COLLABORATIVE

TOWARDS A STANDARDIZATION ROADMAP

the firelight group

ACKNOWLEDGEMENTS

The researchers would like to share our deep gratitude to the focus group participants who shared their expertise, experiences, and profound commitment to First Nations, Inuit, and Métis peoples with us. We know that these conversations are sometimes not easy, but that you participated in the hope of creating better mental health and substance use health systems for Indigenous peoples in this country and for future generations. We thank you for trusting us with your stories.

Final REPORT / Feb. 1, 2024

Prepared and authored by: Firelight Research Inc.

EXECUTIVE SUMMARY

The Standards Council of Canada (SCC) retained The Firelight Group to support the design, development, administration, virtual logistics, and facilitation of initial Indigenous engagement across Canada. The objective was to garner Indigenous perspectives on mental health and substance use health (MHSUH) programs, services, and systems in Canada into considerations for the MHSUH Standardization Roadmap. This report provides background on issues related to First Nations, Inuit, and Métis MHSUH, and summarizes the results of engagements.

Focus groups were selected as the engagement method as a means to generate rich conversations between First Nations, Inuit, and Métis people from across the country, including from service providers, people with lived and living expertise, and policy professionals. Youth, Elders, and 2SLGBTQIA+ folks were also critically important parts of these conversations. The purpose of the engagements was to understand the current state of MHSUH systems for First Nations, Inuit, and Métis peoples across Canada, identify and describe an ideal future vision of MHSUH systems serving Indigenous people, and seeking perspectives on service standards.

Focus group discussions revealed significant challenges within the current MHSUH systems, such as the absence and/or inadequacy of MHSUH services – including First Nations, Inuit, and Métis-specific services – the lack of a continuum of care, persistent anti-Indigenous racism and stigma, the hegemony of western-centric practices, language barriers, and the lack of accounting for the social determinants of health within MHSUH systems.

Looking to the future, focus group participants envision future MHSUH systems as primarily centred on distinctions-based and community-centred continuums of care that support individuals, families, and communities across the social determinants of health. These community-based systems will be connected to partners and jurisdictions though coordination and relationship building. Service providers and partner programs will be fully competent in cultural safety and deliver anti-racist, trauma-informed care.

Finally, focus groups considered the potential benefits and risks of service standards and shared several key considerations as the Collaborative begins developing the Standardization Roadmap. Words and labels are powerful and bring with them history and context. Some participants shied away from the language of standards as a concept with colonial implications and suggested instead the notion of principles as establishing ways of knowing, being, and doing that is more reflective of Indigenous worldviews. This points to a need to be very purposeful and careful in developing both the roadmap and ultimately the standards. Further, these should be distinctions-based and flexible enough to account for cultural, geographic, and community differences.

The focus groups also highlighted the need for standards to be just one element of a larger system and societal transformation that must be built in relationship with Indigenous peoples and reflective of Indigenous self-determination. In terms of themes that emerged as important considerations in developing Indigenous-specific standards, participants advocated for trauma-informed and culturally safe care, holistic and integrated care, Indigenous strengths-based healing integration, reciprocal relationships, Indigenous staff recruitment and retention, and equity.

TABLE OF CONTENTS

1. INTRODUCTION

1.1 OVERVIEW

This summary report provides results from initial Indigenous engagement conducted for the National Mental Health and Substance Use Health Standardization Collaborative (the Collaborative) hosted by the Standard's Council of Canada (SCC). It should be noted at the outset that this report and its contents do not provide the sum of Indigenous perspectives on mental health and substance use health (MHSUH) programs, services, and systems, nor does it purport to represent the perspectives of all Indigenous groups. Further details on the limitations of the engagements carried out and information collected during them is described in Section 1.4 below. Continued engagement of Indigenous groups in the standardization process will be required in order to allow Indigenous participation and leadership in developing and enforcing any standards or initiatives potentially resulting from the Collaborative's work.

1.2 SCOPE OF WORK

The SCC retained Firelight to support the design, development, administration, virtual logistics, and facilitation of initial Indigenous engagement across Canada. The objective of this initial engagement is to garner Indigenous perspectives on MHSUH programs, services, and systems in Canada into considerations for the MHSUH Standardization Roadmap. The main activities Firelight was engaged to perform include:

- Project initiation to develop a project plan and budget based on the scope of work and project goals;
- Design engagement in collaboration with SCC, including identification of appropriate methods for engagement, identification of appropriate participants using a suitable approach, and the development of questions and support materials to be used during engagement;
- Contacting key participants and scheduling focus groups, managing virtual logistics and administration of engagements;
- Engaging with key stakeholders in focus groups; and,
- Developing an overarching summary report (this report) outlining the engagements carried out and level of participation, as well as detailing the feedback heard throughout engagement.

The engagement sought perspectives from First Nations, Inuit, and Métis people on issues related to MHSUH, including diverse perspectives from within these groups, such as women, those with lived and living experience, persons living with disabilities, and members of the 2SLGBTQI+ community. Participation from service providers and policy experts/researchers working within the First Nations, Inuit, and Métis system(s) was also sought.

1.3 METHODS

1.3.1 Approach

Firelight conducted 8 focus groups between November 16 and December 12, 2023, drawing participants from a variety of diverse backgrounds. Each engagement lasted approximately 1.5 hours and was held remotely using Zoom videoconferencing software. Conversations were conducted in a semi-structured manner where a series of predetermined engagement questions guided discussion while leaving room to follow the natural flow of conversation. Participants were welcome to share in any way that felt most appropriate to them, including sharing through storytelling, examples, or other methods. Participants were also welcome to provide input via the comments feature in Zoom.

Participants were eligible to receive an honorarium in recognition of their time and contributions.

The purpose of these focus group was to:

- Better understand the experiences of Indigenous peoples accessing MHSUH services in Canada, including strengths, barriers, and challenges within the current service landscape;

- Gather insights regarding what interventions, approaches or system transformations are needed to improve the safety and experiences of Indigenous people accessing MHSUH services; and,

- Identify topics, themes, and areas of MHSUH which can benefit from standardization of service delivery and determine how standardization may improve care outcomes.

Understanding that these topics are sensitive and potentially painful for some participants, the project team followed best practices in trauma-informed research and facilitation. This included preparing participants for what to expect, and providing connections and support through access to mental wellness resources. In addition, the facilitation team encouraged participants to share in any way that they felt comfortable with, whether that was in written form (via the chat box), or through storytelling. Out of a desire to center Indigenous methods (i.e., storytelling) and to honour and show respect for the people who generously shared their experiences, this report, where possible, includes these deeply personal and important stories.

1.3.2 Participants

A total of 33 people participated in the focus groups. Participants were invited to self-identify, and could identify as “First Nations”, “Inuit”, “Métis”, “Non-Indigenous” or a combination of these. Most participants in the focus groups spoke on behalf of themselves, from their own expertise and experiences. However, there were some who participated as representatives from Indigenous organizations that shared information from an organizational perspective, and identified as non-Indigenous.

Table 1: Focus Group Participants

TOTAL	**33**
First Nations	21
Inuit	4
Métis	6
Non-Indigenous	2

Participants were also invited to select one or many of the following identity markers, allowing participants to self-identify and choose from a range of options.

Table 2: Focus Group Participants: Intersectional Identities

Elders	7
Youth	6
2SLGBTQIA+	4
Women	21
Persons with lived or living expertise	20
Substance use health service providers	11
Mental health service providers	19
Policy	11

In terms of geography, focus group participation was fairly broad, including folks from the north, the west coast, the prairies, central Canada, and the Atlantic. There is also a category called "National" which includes participants who represent organizations with a national mandate.

Table 3: Geographic Representation of Focus Group Participants

British Columbia	9
Alberta	2
Saskatchewan	1
Manitoba	2
Ontario	4
Quebec	4
New Brunswick	0

Nova Scotia	0
PEI	1
Newfoundland and Labrador	2
Yukon	2
NWT	1
Nunavut	0
National	5

1.4 LIMITATIONS

The information contained within this report is based on feedback provided during a limited number of initial engagements with First Nations, Inuit, and Métis people. While this summary report is based on engagement with Indigenous people and organizations, the contents of this report should not be in any way construed or interpreted to represent a pan-Indigenous perspective on MHSUH. As highlighted by participants throughout, issues, priorities, and perspectives vary both across and within First Nations, Inuit, and Métis groups, as well as between regions and jurisdictions in Canada.

2. CONTEXT OF INDIGENOUS MENTAL HEALTH AND SUBSTANCE USE HEALTH

2.1 WELLNESS OUTCOMES

A comprehensive discussion of the current MHSUH outcomes for First Nations, Inuit, and Métis in Canada is beyond the scope of this report. However, it is important to provide a high level look at current wellness outcomes, in particular given the persistent gaps between Indigenous and non-Indigenous people in Canada, to better understand the urgency felt by many participants within these engagements to make meaningful and sustained system improvements.

Mental health for First Nations, Inuit, and Métis in Canada is a persistent gap compared to non-Indigenous people in Canada. In 2017, 16% of Indigenous adults were found to have poor to fair mental health, which increased to 38% during the COVID-19 pandemic (Anderson, 2021). Indigenous youth are also more likely to suffer from poor mental health than non-Indigenous youth in Canada, with one in five being diagnosed with a mood disorder, and almost a quarter diagnosed with an anxiety disorder (Anderson, 2021). Suicide is also acknowledged as an epidemic for Indigenous youth, with rates among Indigenous youth being six times higher than non-Indigenous youth in Canada (CAMH, 2023). And finally, substance use is another key concern for First Nations, Inuit, and Métis – where 25% of Indigenous peoples in Canada, compared to 17% of the general public, struggle with addiction (Toth, 2022).

2.2 COLONIAL CONTEXTS

The statistics presented in here are shocking and important, but they also only tell part of the story. Throughout these engagements, participants noted the need for service providers and policy professionals working in the areas of mental health and substance use health to understand the historical and contemporary contexts which deeply shape the experiences of First Nations, Inuit, and Métis peoples in Canada. Thus, it is important to provide a brief overview of these factors to better contextualize the report that follows.

Mental health and substance use health outcomes among Indigenous populations are strongly tied to colonialism. Colonial policies and programs such as the dispossession of land, the residential school system, the separation of Indigenous families and severing of language and culture has led to widespread intergenerational trauma (Marsh et al., 2016). This trauma has left many communities, families, and individuals struggling with loss, grief, and separation from cultural and familial ties. Research has shown that there is substantial evidence linking traumatic experiences in older generations with physical and mental health challenges in later generations, whether those traumatic events were individual experiences or collective experiences (Thunderbird Partnership Foundation, 2023).

For many Indigenous people experiencing a loss of culture and community as a result of colonial policies, mental health challenges, the use of harmful substances, and addiction are all rooted in a common colonial experience. In a report from the Thunderbird Partnership Foundation, Dr. Chris Mushquash, an Ojibway psychologist and Canada Research Chair in Indigenous Mental Health and Addiction, notes, "the removal of children from thriving communities with strong culture caused significant trauma which was compounded by the introduction of problematic substances and activities. It became natural to self-medicate with substances…when culturally based approaches to healing, including ceremonies, had been taken away" (Thunderbird Partnership Foundation, 2023, p. 11). The complex and intertwined relationships between colonization, intergenerational trauma, mental health, and substance use health are important to recognize as contextualizing much of this work.

Furthermore, research has also shown that there is a strong link between the social determinants of health, such as poverty, unemployment, housing, and education, and poor mental health or the use of illicit substances (Carriere, Garner & Sanmartin, 2022). These conditions are more prevalent among Indigenous peoples as a result of historical and ongoing colonial practices, and therefore, Indigenous peoples often experience higher rates of mental health and substance use health challenges, and overdose deaths (Thunderbird Partnership Foundation, 2022). In fact, a 2022 study has revealed that Indigenous people living in crowded housing conditions (i.e., households of seven people or more), those experiencing food insecurity, and those who have experienced trauma were significantly more likely to use opioids in a harmful way (Thunderbird Partnership Foundation, 2022, p. 8).

The connection between SDOH and mental wellbeing and substance use health is particularly troubling given the persistently challenging social conditions in which many Indigenous people live reflected in poverty, education, and housing statistics. For example, a Statistics Canada report shows that, “Indigenous people were almost twice as likely to live in crowded housing in 2021, compared with the non-Indigenous population (17.1% versus 9.4%) (Government of Canada, 2022, p.3). Notably, rates of overcrowded housing have gotten worse between 2016 and 2021 for Inuit living outside of Inuit Nunangat (the Inuit homeland), Nunavik, and the Inuvialuit region (Government of Canada, 2022). Related to education, “Just under two-thirds (63%) of all First Nations youth had completed high school, compared with 91% of the non-Indigenous population” with only 46% of First Nations youth living on reserve completing high school, largely as a result of lack of local access (Layton, 2023, p. 4).

Related to poverty, the National Advisory Council on Poverty reported that in 2018, the national poverty rate was 11%, while the rate for Indigenous peoples living off reserve was 19.5% (National Advisory Council on Poverty, 2021). These few statistics clearly demonstrate that the connection between colonialism, social determinants of health, and mental and substance use health must be central to the discussion of generating standards that are responsive and relevant to the context of First Nations, Inuit, and Métis people’s lives.

A Note:

Throughout the engagements, many participants shared a desire to focus on the profound strength within First Nations, Inuit, and Métis peoples and cultures. So, while colonial harms have, and continue to contribute negatively to the wellness of Indigenous peoples, it is also important to affirm the historical and contemporary strength, expertise, and wise approaches within Indigenous communities for building individual, family, and community strength, and responding to mental health and substance use health challenges. Additional information about these practices is found throughout the report that follows.

3. WHAT WE HEARD

3.1 CURRENT STATE

Each focus group paid significant attention to describing the current state of MHSUH programs and services. Gaps and shortcomings were identified at the provider, institutional, and jurisdictional levels for individuals, families, and communities. Systemic gaps include the absence of available and appropriate MHSUH services, both at provincial/territorial and federal levels. Where services do exist, they are not meeting the specific needs of First Nations, Inuit, and Métis people, both in terms of cultural relevancy and safety, as well as responding the socio-economic contexts of Indigenous peoples which contribute to wellness outcomes. In addition, there exists a significant gap in a continuum of care that supports people throughout their healing journeys; a gap that is oftentimes based in policy, and often due to material or perceived jurisdictional chasms between federal and provincial/territorial responsibilities. Additional barriers include persistent anti-Indigenous racism and stigma facing First Nations, Inuit, and Métis people within MHSUH systems at interpersonal, institutional, and systemic levels. The following section provides greater detail of these key gaps and issues that characterize the current state of MHSUH for Indigenous peoples.

3.1.1 Absence of Services/Lack of Continuums of Care

The most common response to questions around the performance of current MHSUH programs and services heard throughout the engagements was a general sense that First Nations, Inuit, and Métis people lack access to programs in general, and an even more acute lack of access to Indigenous-specific programs and services. One participant noted that healthcare systems across the country are in crisis and the result is that Indigenous and racialized people are deprioritized first. In addition, they shared their perspective that when healthcare workers are overwhelmed, they often lose empathy and cultural sensitivity (Participant, Nov. 29, 2023). Other participants shared that the system is currently so taxed that most care comes from emergency departments where there are few mechanisms to ensure adequate follow up or after care, and where aftercare exists, the referral process is complicated and inaccessible (Participant, Dec. 7, 2023).

The simple fact is, there is simply no MHSUH programs and services in many parts of Canada, particularly in rural and remote areas and the north. A participant from Nunatsiavut shared that they did not know that treatment centres existed until they moved to an urban community in the south. They added that the only thing resembling detox in Nunatsiavut was “lock up” (Participant, Nov. 29, 2023). People in rural and remote areas seeking MHSUH services are often forced to travel long distances for care, away from established support systems. A participant described a kind of culture shock being amongst only non-Indigenous people when accessing services within an urban centre far from home and described this discomfort as a significant barrier to healing (Participant, Dec. 7, 2023).

Policy Barriers

MHSUH programs and services that do exist are only useful so long as Indigenous people can access them. Focus group participants identified several program policies and regulations that create barriers to care for Indigenous peoples within MHSUH that amount to a service gap. One service provider participant from Yukon detailed challenges in accessing psychiatric care for clients not currently using substances. They described a client who was an intergenerational survivor of residential schools, clearly in crisis, and could not access a psychiatrist unless they were using substances. Additionally, their clients who struggle with substance use but are not currently using substances (within 5 days) are not eligible for rehab programs (Participant, Dec. 5, 2023).

Another often-cited barrier to care is program regulations requiring a diagnosis prior to receiving care. Generally speaking, it is difficult to access care providers who are able to provide a diagnosis both because of a shortage of providers, but also as a result of policy choices. One participant shared that access to many programs and services require a permanent address. This makes it very difficult for those living without a permanent address to access service providers (Participant, Dec. 7, 2023). Layered onto this is the challenge of accessing care providers with an understanding of or training in the specific needs and realities of Indigenous peoples. These sorts of providers are even less available. For example, one Inuk participant shared their struggle of trying to access a therapist. Each provider they approached said they were not equipped to respond to the client's needs. The person seeking care shared that they felt like "they were too messed up" to even get help (Participant, Nov. 29, 2023). They added that this was a common experience amongst their Inuk relations.

Jurisdictional Barriers

Another unique barrier faced by Indigenous people are jurisdictional uncertainty and barriers between federal and provincial/territorial governments and health authorities. Federal services, though insufficient, are offered to status First Nations people and Inuit beneficiaries through Indigenous Services Canada (ISC) as a result of Section 91(24) of the *Constitution Act, 1982* which assigns the federal government with legislative authority over "Indians and lands reserved for Indians". At the same time, the *Canada Health Act* establishing the right of **all residents** within provinces and territories to healthcare. While this should, in theory, result in overlapping services, this more often results in program gaps as provincial/territorial programs, services, and providers often claim that Indigenous health provision is a federal responsibility.

The consequences of this gap are profound. One participant talked about the experience of their brother living with schizophrenia. He was not able to get consistent care, which resulted in interactions with the justice system. The reason he was not able to access consistent care was "because the care providers [acute care team] refused to drive the roads on reserve, the same roads that we used for non-Indigenous patients, living slightly outside of the reserve." (Participant, Dec. 7, 2023). Beyond simply a lack of care, this comment points to the problem of a lack of coordination between community, provincial/territorial, and federal programs and services. Clients and patients, who are often struggling with mental health and substance use health, are expected to navigate these jurisdictional chasms themselves.

Inadequate Support for Community-Based or First Nations, Inuit, and Métis-Specific Services

These engagements revealed a strong sense that the First Nations, Inuit, and Métis-specific services across Canada are largely pilot projects, with short term, inadequate funding. However, a system built on pilot projects is not comprehensive. For example, one participant shared, "sometimes you'll see a great program come around, then someone goes to access it and the service doesn't exist anymore or was disrupted because of lack of funding or resources" (Participant, Nov. 16, 2023).

One result of limited funding has been tight policies around who is eligible for programs and services. One service provider participant shared, "it's hard to access culturally relevant programs if you aren't registered to a community or a Métis Nation. In urban centers it can be better, but it can still be a big challenge to overcome that barrier, do that genealogy work, and be connected to a community" (Participant, Nov.15, 2023). In this example, a Métis person who is not yet a member of a Métis organization, but who is seeking MHSUH supports, is first required to undergo a comprehensive application process which involves undertaking genealogical research before being able to access care.

Similarly, federal funding for health services on reserve through Indigenous Services Canada (ISC) generally follow a funding formula which provides funding based on band membership numbers. This excludes people who live in the community but are not band members. This creates a significant challenge for First Nations who have to decide whether to provide care for people that they are not receiving funding to support, or they have to turn away members of their communities. This creates community tension and potential service gaps.

Participants shared that the lack of available options for Indigenous-specific services puts Indigenous people in a position where they lack choice or options. Participants clearly connected this lack of choice to the decades of colonial policies that took away the agency of First Nations, Inuit, and Métis peoples. These include compulsory participation within residential schools and enforced segregation in Indian hospitals. It was felt that, in real and profound ways, the current MHSUH system – which does not provide meaningful choices for Indigenous peoples – is a mere continuation of these more blatant colonial policies, and have the potential to entrench rather than respond to the colonial roots of Indigenous peoples' mental health and substance use challenges (Participant, Nov. 16, 2023; Participant, Dec. 7, 2023).

Inadequate ISC Services and Funding

In addition, to inadequate services at the provincial and territorial levels, focus group participants shared challenges related to the federal provision (via ISC) for MHSUH programs and services for First Nations communities. The general feeling from the focus groups about ISC funding is that funding for First Nations community programs tends to be siloed with inadequate supports for prevention which makes developing a comprehensive continuum of care difficult. One participant summarized it simply with, "we do not have funding to provide wrap around services, harm reduction services to address the opioid and meth crisis. [We have] no funding for prevention, only the reaction to the crisis" (Participant, Dec. 7, 2023).

3.1.2 Anti-Indigenous Racism and Stigma

Perhaps the most often cited barrier for First Nations, Inuit, and Métis people receiving adequate and safe MHSUH care is the persistence of stigma and anti-Indigenous racism amongst providers and programs. These issues exacerbate existing disparities, impede access to care, and perpetuate negative stereotypes, ultimately hindering effective treatment and support. Negative stereotypes and misconceptions about Indigenous peoples persist, leading to stigmatization in mental health and substance use health contexts. This stigma can deter individuals from seeking help due to fear of discrimination or judgment, further isolating them from accessing crucial support services.

Focus groups revealed the tragic consequences of racism and stigma combined with inadequate access to care. One First Nations participant shared the story of losing two children to overdoses after both were failed by the MHSUH system. One child suffered chronic pain from a past injury and healthcare staff, due to stigma and racism, were unwilling to provide adequate pain management. Desperate for reprieve, the participant's son sought pain killers through an acquaintance on social media. Unfortunately, he received toxic drugs and sadly passed away. The participant's daughter suffered debilitating rheumatoid arthritis. Doctors were also unwilling to provide her with adequate pain management. In order to find pain relief, the participant's daughter had to place herself into positions that made her vulnerable to acts of violence. The participant's daughter was tragically murdered, highlighting the connection between failing MHSUH systems and other deplorable realities in Canada such as missing and murdered Indigenous women and girls (MMIWG) (Participant, Nov. 28, 2023). Thus, the intersection between racism, stigma, inadequate systems of care, and gender are vital to consider in any conversation around MHSUH standards.

Like MMIWG, the connection between MHSUH and the overrepresentation of Indigenous children in foster care systems is direct and profound. A First Nations participant shared her experiences as a former street involved person who used substances and sought support when she became pregnant. Despite having successfully detoxed off substances for her pregnancy, this participant shared their fear in seeking support, a fear that was well founded when child and family services (CFS) attempted to apprehend their child at birth (Participant, Nov. 28, 2023). This same participant, now a service provider, shared another common stigma within MHSUH; that is, stigma faced by people working within the sex industry and how it intersects with anti-Indigenous racism. They shared that this results in hesitancy of people working within the sex industry to seek MHSUH services (Participant, Nov. 28, 2023).

The focus groups also highlighted the challenge of relying on western-centric approaches to MHSUH that, beyond lacking cultural relevancy, can be simply racist. One Métis service provider participant shared that, "things like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), there's value [to them] but they're not Indigenous-led, there's no Elder there, it doesn't start in ceremony, it tends to be very Christianized" (Participant, Nov. 15, 2023). An Inuk participant described moving from their home community in the north to an urban centre in the south. One of the only accessible supports was AA, which they joined. Firstly, all the other participants were non-Indigenous so, coming from a small Inuit community, the environment did not feel safe (Participant, Nov. 29, 2023). Secondly, the participant was faced with educational materials that were flatly racist. They quoted the exact page in AA's "The Big Book" that states:

"An Elder might interpret things differently from [western] service providers. There are Medicine People who see those gifts, while others see it as a diagnosis."

-Participant, Dec. 6, 2023

> *Assuming we are spiritually fit, we can do all sorts of things alcoholics are not supposed to do. People have said we must not go where liquor is served; we must not have it in our homes; we must shun friends who drink; we must avoid moving pictures which show drinking scenes we must not go into bars; our friends must hide their bottles if we go into their houses; we mustn't think or be reminded about alcohol at all. Our experience shows that this is not necessarily so.*
>
> *We meet these conditions every day. An alcoholic who cannot meet them, still has an alcoholic mind; there is something the matter with his spiritual status. His only chance for sobriety would be some place like the Greenland Ice Cap, and even there an Eskimo might turn up with a bottle of scotch and ruin everything* (W. Bill 2002, p. 101).

The participant shared that this made them feel exposed and hurt; as if Inuit are inherently bad. It is very troubling that this sort of racism comes from one of the only substance use health support programs available to many Indigenous people across Canada.

3.1.3 Hegemony of western-centric practices

Closely related to anti-Indigenous racism within MHSUH systems, many focus group participants cited the hegemony of western-centric practices within MHSUH programs and services as a significant challenge faced by First Nations, Inuit, and Métis people seeking care. Western frameworks often prioritize individualistic perspectives, evidence-based interventions determined using western methods, and standardized diagnostic criteria. These approaches do not often align with the communal, holistic, and spiritually integrated healing practices found within many Indigenous cultures.

Focus group participants shared that, the exclusion of Indigenous practices and the privileging of western practices contributes to the erosion of cultural identity and community cohesion that is, in many cases, the root of mental health and substance use health challenges for Indigenous peoples. By way of example, one participant shared how the use of adverse childhood experiences (ACE) metrics can cause harm for Indigenous patients and clients. They shared, "as Indigenous people, we will score higher because of our lived experiences. We are put in a deficit situation. No mechanism to remove a diagnosis from our records, which becomes what defines who we are in the future… [the] lack of understanding of our lived experiences becomes a huge barrier." (Participant, Dec. 7, 2023).

Several ways in which western-based approaches are reflected in the design and delivery of MHSUH programs and services were identified. Examples include an individualistic focus within diagnostics, therapeutic approaches, individualized treatment goals, and limited consideration for the social determinants of health including cultural, social, and familiar factors. One participant shared that this individualist focus results in gaps between these western-based MHSUH services and family, community-based resources, and peer networks. A Métis service provider shared:

> *So often it's recommended that family work is best and most effective, especially with youth, but it's hard to access it. I'm thinking of a patient; it was hard in their recovery journey because part of that was repairing relationships with relatives, but that's hard if they aren't in therapy themselves – the community was very helpful there because they brought everyone together… It goes a long way in helping the family feel more comfortable and confident in supporting the individual, it's usually related to the whole family dynamic* (Participant, Nov. 16, 2023).

3.1.4 Language barriers

Several focus group participants noted language as a barrier for some First Nations, Inuit, and Métis peoples in receiving high quality MHSUH care. The availability of interpretation or translation for various Indigenous languages within most healthcare settings is limited which can leading to misunderstandings or incomplete exchanges of information.

A related concerned was raised by several participants from Quebec, stemming both from Indigenous peoples whose first language is their Indigenous language, and for anglophones. All health and social services delivered by the province of Quebec are provided in French. However, roughly half the First Nations communities in Quebec are primarily English-speaking. In addition, there is a significant Inuit population within Quebec, including in Montreal where many Inuit go to receive healthcare services. Language barriers make it difficult to find suitable care providers, and limit access to important health information, educational materials, and resources.

3.1.5 Not Accounting for the Social Determinants of Health

Finally, a common theme that permeated each of the focus group dialogues was the inability of the current MHSUH systems to adequately address the social determinants of health (SDOH). It was felt that the sources of this challenge are both societal/cultural and policy/political. The dominance of the western-centric biomedical model which seeks to treat individuals are less able to account for broader social contexts in which MHSUH challenges emerge. Many current programs and services occur within clinical settings which may obscure the role that the SDOH play, including poverty, racism, and housing insecurity. Regarding the political and policy roots of this inability to address the SDOH, the fragmentation of services between the private and public sectors, and various jurisdictions, makes collaboration to address the SDOH challenging. In addition, participants shared the persistent lack of resources dedicated to alleviating inequity in the SDOH as a political decision which perpetuates harm.

3.2 FUTURE VISION

Very clearly, focus group participants feel that current MHSUH care is inadequate to address the needs of First Nations, Inuit, and Métis individuals, families, and communities. However, the focus group revealed a clear vision of what is required to respond to the MHSUH concerns of Indigenous peoples and create empowered, self-determined, communities to generate future generates of health and flourishing Indigenous people.

3.2.1 Distinctions-based, Community-centred Continuums of Care

> "Ideally MHSUH systems would be built around relationships within community. There would be time, funding, and space to develop treatment plans that see a person holistically and support, not only the individual, but the family and wider community to thrive as a whole… Healthy food, connection with land, with community, with spirit, with sense of purpose and belonging… are all central to thriving."
>
> - Participant, Dec. 7, 2023

A huge theme that emerged from the focus group discussions on a future vision for MHSUH programs and services that meet the needs of Indigenous peoples is a huge push for distinctions-based[1] and community-centered programs and services organized into a continuum of care that attends to the physical, mental, emotional, and spiritual needs of individuals, families, and communities. These services need to be where people live, whether that be in urban centres or rural, remote, and northern communities.

Provincial/territorial and federal governments hold an obligation to ensure communities are fully supported to plan, develop, and deliver programs themselves ensuring programs and services are tailored to each community's unique and specific context. This point recognizes the notable diversity both within and between First Nations, Inuit, and Métis cultures and contexts. One participant described the importance of centering culture in healing by sharing that it allows the transmission of important teachings including "the significance around the way of life that enabled [our] ancestors to survive" (Participant, Nov. 20, 2023). Another participant shared the

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[1] 'Distinctions-based' refers to policies and programs which are designed based on the understanding of the unique and diverse needs of First Nations, Inuit, and Métis peoples in Canada. Rather than a one-size-fits-all approach, distinctions-based approaches seek to respond to these unique needs based on each community's characteristics, which may include socio-economic and historical contexts, Treaties and relationships, and cultural practices, among others.

importance of including language learning in MHSUH programs because Indigenous languages are imbued with wisdom around land, culture, and healing. One participant described a successful land-based program that embodies all of these insights. They shared:

> *The success of the program can be attributed to the nature of the program based on relationship-building, collaboration with others, and leadership. We lived on the land together. [We did the opposite of what colonialism did by] taking away children to residential schools, separating them from community, land, family* (Participant, Nov. 20, 2023).

Very much aligned with this view was another participant who shared, "when I think of reconciliation, I think of what was taken away: language, knowledge, traditional parenting, traditional knowledge. What needs to be fixed is investing a way bigger amount to bringing that back." (Participant, Nov. 16, 2023). Affirming the value of culture in healing, a participant described how moving back to their homeland really supported their healing journey as it made access to land, culture, and Elders much easier. Increased opportunities for this kind of reconnection are very important.

"I wanted to say about the ideal system, there would be a genuine 'no wrong door' approach. That's used so much lately and then there is a wrong door! They love to throw around 'meeting people where they're at', but that really looks like an integrated system looking at housing, income, employment, cultural support, those holistic wellness needs. Holistic wellness looks like someone who might not be ready to reduce substance use, but needs access to housing, and we have housing programs but how do you call those programs when there's no counsellors on site, no wellness activities? So, introducing those people to housing is the first step and having a healthier routine is helpful, giving people more options to assert that 'this is what I'm ready for right now, this what I want and need right now' is important."

- Participant, Nov. 16, 2023.

Focus group participants shared that undergirding the notion of culture as foundation and centering First Nations, Inuit, and Métis practices within MHSUH is a focus on a strengths-based language and practices that work to identify and leverage individual, family, and community inherent strengths, abilities, and resources to promote recovery, resilience, and well-being. This approach is particularly important when addressing First Nations, Inuit, and Métis MHSUH given their unique cultural, historical, and social context in Canada. For example, strengths-based approaches better reflect communal values and interconnectedness that are at the foundation of many Indigenous cultures. In addition, Indigenous communities have survived and persisted despite a barrage of colonial harms perpetuated over centuries. Ancestral knowledge about caring for one another has been maintained and is actively being rebuilt. This should rightly be a source of pride, empowerment, and wellness for Indigenous people and communities. Finally, strength-based approaches rooted in First Nations, Inuit, and Métis ways are a reflection of Indigenous self-determination and cultural continuity which, it itself, is an important determinant of health.

"Why do we always have to talk about how we're broken? Why can't we talk about how deadly it is to be Inuk?!"

- Participant, Nov. 29, 2023

Another important conceptual distinction made was the way in which harm reduction is conceived of and implemented within many Indigenous communities. In contrast to the individualistic models of care within western-based care models, focus group participants shared a vision of harm reduction as being much more than preventing harm to individuals. Indigenous harm reduction is about developing programs and services reduce harms to individuals, families, and communities and address the harms caused by colonialism.

3.2.2 Supporting the SDOH

The engagements revealed widespread difficulties faced by First Nations, Inuit, and Métis peoples within their healing journeys when they are struggling to meet the basic necessities of life such as housing and food security. As noted in Section 3.1.5, it was felt that current MHSUH systems for failing to adequately address the SDOH of individuals, families, and communities. In contrast, the participants future vision includes integrated programs and services across the continuum of care that directly address the social, political, and economic conditions that impact the health and wellbeing of First Nations, Inuit, and Métis peoples. Supporting the SDOH within MHSUH programming could include:

- The integration of MHSUH services within broader health and social services initiatives that address social determinants such as access to housing, education and training, employment, and recreation, among others;
- Increased education and awareness about the impact of SDOH within First Nations, Inuit, and Métis contexts on MHSUH outcomes to address stigma and health literacy;
- An advocacy function that seeks to guide policy and program changes at local, regional, and national levels towards a comprehensive approach to MHSUH and the SDOH;
- Prevention strategies that work towards creating healthy communities, starting from early childhood and continue through all the life stages utilizing local context and cultural ways of knowing, being, and doing.

Participants also flagged the need to take into consideration the unique needs of communities within communities in program planning and delivery, such as women, youth, Elders, and 2SLGBTQIA+ people. For example, one participant shared a past experience where women, who were working hard to get healthy in order to keep their children within their care, were unable to access a land-based healing program because the programming did not include children or make accommodations for children. Involving people with lived and living expertise in program design will help support this objective.

> "[An organizational structure to support cultural safety and trauma informed approaches requires] a big systematic transformation! It's at every level, it's how the organization is structured; is it top-down? Do people at the bottom get a say in what happens or are they just responding to what happens? Is there circular communication? Are there good mental health benefits? Things that really support what makes us feel well in our everyday life."
>
> - Participant, Nov. 16, 2023

3.2.3 Jurisdictional and program coordination

While there was significant attention paid by focus group participants in building up community-based MHSUH services, there was also a simultaneous recognition of the need to coordinate with programs and services outside of community-run programs including provincial/territorial services. This can be supported by deep and meaningful relationship building, clear protocols for information sharing and communications, cross training and professional development, multi-disciplinary and multi-jurisdictional teams with potential for co-locating services, Indigenous patient navigators, and established data sharing in alignment with Indigenous data protocols. One example is First Nations' OCAP® principles.

3.2.4 Cultural safety and anti-racism

As mentioned in Section 3.2.3, focus group participants acknowledged the ongoing important role of mainstream MHSUH systems in providing programs and services for Indigenous peoples in Canada. As such, significant focus was paid to ensuring all programs and services serving Indigenous people are culturally safe and free from racism. Participants shared frustration with some past and current efforts said to address anti-Indigenous racism and towards cultural safety that were seen as performative and surface level. What cultural safety within MHSUH systems demands is no less than system transformation (Participant, Nov. 20, 2023; Participant, Nov. 16, 2023). This transformation must begin with a clear and honest accounting for the truth of colonialism and the continued manifestation of colonialism through systemic means. This transformation must take place within reciprocal relationships between MHSUH systems and Indigenous peoples based on humility and commitment to be in good relations. Through these relationships, specific actions can be taken to work towards cultural safety and challenging anti-Indigenous racism. Focus group participants identified the following actions as promising practices undertaken through these relationships:

- Mandatory and ongoing anti-racism and cultural safety training for all staff tied to performance reviews;
- Widespread training in trauma informed care and Indigenous harm reduction approaches;
- Respecting First Nations, Inuit, and Métis ways of knowing, being, and doing including healing approaches and measurement and evaluation of program success;
- Recruitment and retention of First Nations, Inuit, and Métis staff and systems to support their meaningful and safe participation in systems; and,
- Organizational and policy support, and allocated resources to ensure the success of the above-mentioned work.

3.3 SERVICE STANDARDS

The engagements included numerous robust discussions on the potential promise and pitfalls of MHSUH service standards, in particular within the Indigenous context. While generally recognizing their potential value, several groups discussed a certain discomfort around the notion of service standards. Historically, Indigenous peoples have been, often through violence, forced to

> "The thing that makes me nervous about standards is really around who develops the standards and how they're developed. Indigenous standards are different, there's a different cultural and political context. Sometimes it ends up repeating colonial ideas of who is a 'proper' or 'regulated' provider and that doesn't always acknowledge the expertise of lived experience and traditional teaching, so knowing Indigenous ways are just as respected is important."
>
> - Participant, Nov. 16, 2023

conform to non-Indigenous systems and worldviews. There is concern that service standards could embed and enforce a western-centric model of MHSUH care. One participant shared, "standards are linear, firm, black and white" which may not provide the flexibility necessary to support Indigenous healing practices and care providers (Participant, Nov. 20, 2023).

Whereas service standards were described as rigid, several participants resonated with the concept of principles. One First Nations participant shared, "principles will speak to a value but also is a strategy to accomplish something. It has embedded relationships into it. Cultural safety is more feasible when operating on principle as opposed to standards. It makes it easier to bring culturally different people to work creatively" (Participant, Nov. 20, 2023). It was also shared that principles allow for the required flexibility to meet specific contexts and encourage providers and systems to strive for excellence, rather than reaching a standard. In the discussion on standards versus principles, one participant suggested that service standards might actually be a step back from the systems transformation that is necessary in a project of cultural safety within MHSUH.

Clearly there is not consensus on the value of standards versus a conceptual framework based on principles. This points to the need for further dialogue within the standards development process that seeks to respond to the perceived shortcomings of a standards framework that have been surfaced by thinking through an approach grounded in principles.

With these important caveats in mind, the following section details considerations raised by participants generally supportive of the concept of standards.

3.3.1 Connection to Existing Standards Regimes

One service provider participant noted that several professional colleges already have practice standards around cultural safety, including the BC Association of Clinical Counsellors' *Standards of Clinical Practice: Indigenous Cultural Safety, Cultural Humility, and Anti-Racism* (2023). This raised the notion of ensuring that, within the process of developing any new standards, attention is paid to considering existing regimes and how they align or diverge. In addition, consideration should be made regarding how accountability is ensured for new standards in relationship to any existing accountability mechanisms.

3.3.2 Equitable Access

As noted throughout this report, access to high-quality, relevant, and safe MHSUH programs and services for Indigenous people is a persistent challenge across Canada. As such, participants suggested a specific focus on *equitable access* within any proposed standards approach. Such a standard should ensure that mental health and substance use health services are accessible to all individuals, irrespective of their background, abilities, socio-economic status, location, and culture. Equitable access means ensuring physical, linguistic, financial, and technological accessibility and availability of culturally appropriate and safe services where and when they are required.

3.3.3 Indigenous-Specific Themes

In addition to providing direction on what a good process in developing MHSUH standards would look like, focus group participants identified some key areas that may benefit from standardization.

- *Flexibility:* Standards must be flexible in order to allow for client-centred care, as well as diversity within and between First Nations, Inuit, and Métis cultures and perspectives. In addition, standards must account for the unique needs of all Indigenous people.

- *Trauma informed and culturally safe care:* Standards should emphasize the importance of mental health and substance use health professionals being culturally safe and respectful of Indigenous cultures, values, and traditions. This includes understanding diverse First Nations, Inuit, and Métis perspectives as well as local community contexts, on health and healing, and should result in an environment where First Nations, Inuit, and Métis clients feel respected, understood, and free from discrimination. Providers must also incorporate trauma-informed approaches that respond to the historic and contemporary trauma faced by Indigenous peoples rooted in colonialism.

- *Holistic and integrated care:* Standards should promote MHSUH care which attends to the physical, mental, emotional, and spiritual wellbeing of Indigenous people, including attending to the SDOH. This also requires ensuring Indigenous clients do not get trapped within jurisdictional or programmatic gaps.

> "[Currently] it is normally white people assess[ing] if white people can serve us as Indigenous people."
>
> - Participant, Dec. 7, 2023.

- *Indigenous strengths-based healing integration:* Standards should emphasize the importance of Indigenous healing practices and ensure providers actively facilitate their inclusion when supporting First Nations, Inuit, and Métis clients.

- *Reciprocal relationships:* Standards should support the development and maintenance of reciprocal relationship with Indigenous people and communities at the provider, program, and system level. This should be reflected in program design, implementation, evaluation, and ongoing quality improvement.

- *Indigenous staff recruitment and retention:* Standards should generate support for dedicated efforts to recruit and retain First Nations, Inuit, and Métis staff, including within positions of leadership. This includes ensuring pay equity and acknowledgement of expertise that falls outside of the western-centric care model (ex., Elders, Knowledge Keepers, peers).

- *Equity:* Standards should ensure MHSUH programs and services are geographically, financially, and culturally accessible to Indigenous communities at a level consistent with the level of needs, with a priority of supporting Indigenous-developed and run programs within Indigenous communities themselves.

3.3.4 Accountability

In speaking about MHSUH standards, there was a key message shared across focus groups: For standards to have an impact, there needs to be accountability, and what that accountability looks like, and who is measuring it, matters. In general, there was support for the notion of a third-party to monitor adherence to standards. However, it is very important that the third-party have the capacity and appropriate expertise with deep understanding of First Nations, Inuit, and Métis socio-political contexts, and ways of knowing, being, and doing.

The need for this expertise was highlighted by a story shared by a focus group participant. They described a researcher asking an Elder about the size of the bear population one year. The Elder responded that there were "lots of berries that year". The researcher assumed the Elder misunderstood the question. However, someone who understands the cultural context would know that the Elder was expressing that the bear population was low because there were still many berries out (Participant, Dec. 5, 2023). Evaluation must reflect First Nations, Inuit, and Métis values (metrics) and methods.

In addition, many focus group participants described a desire for a third-party accountability structure to be a site for relationship building and capacity development. This speaks to the earlier discussion around the value of principles in that they embed relationships in taking concrete actions towards providing safe and high quality MHSUH care. At least in the near term, non-Indigenous service providers and organizations will play a role in MHSUH delivery for Indigenous peoples; however, gaining competency in such complex topics as cultural safety, how to be in good relations with Indigenous communities, and the safe and meaningful integration of Indigenous healing methods is difficult and takes time. Participants shared disappointment in the inadequacy of current cultural safety trainings that have been taken up in health systems across Canada. Considering this gap, many saw the potential for this third-party organization to also support implementation of those standards though knowledge sharing and capacity building, in addition to evaluating, monitoring, and reporting on adherence to First Nations, Inuit, and Métis-specific service standards.

Very clearly, whomever is tasked with promoting and upholding standards must have the requisite skills, credibility, and cultural/contextual knowledge described above. Some other potential actions raised by the focus group participants that may generate accountability to service standards include:

- Generating opportunities for collaboration, shared learning, and peer review of programs and services to advance best practices and facilitate relationship building;

- Establishing and promoting clear standards, guidelines, and supporting their implementation;

- Development of culturally and contextually relevant performance metrics that are continually monitored, evaluated, and adjustments made based on results;

- Transparent and regular reporting on results;

- Establishing mechanisms for individuals, families, and communities to report concerns or complaints about MHSUH providers, programs, and systems; and

- Generating an oversight mechanism to monitor and enforce standards.

4. RECOMMENDATIONS

The preceding sections provided significant insight into areas for exploration in developing MHSUH standards themselves. The section below provides recommendations related to advancing the work of the MHSUH Collaborative and the Standardization Roadmap in a good way.

1. The engagements provided a clear message that Indigenous peoples are not satisfied with merely tinkering around the edges of a system that is hurting them; rather, energy is focused on bold, transformative changes. As such, **MHSUH service standards must be viewed as one part of a larger system and societal transformation that requires specific efforts to support Indigenous self-determination undertaken in partnership with Indigenous peoples**.

2. The approach taken in all future engagement, development, and co-development should be, first and foremost, guided by the understanding that since time immemorial Indigenous peoples have possessed the expertise, knowledge, and wisdom to generate healthy individuals, families, communities, and Nations. Despite colonial efforts to silence it, **this expertise remains, and is the foundation on which effective and equitable MHSUH systems must be built for Indigenous peoples in Canada**.

3. As noted in this report, within the focus groups were complex and sometimes diverging perspectives regarding the promise and potential pitfalls of MHSUH standards. In addition, many participants expressed concern that these short focus groups would be the only engagements related to the development of service standards. It was broadly felt that the **process for standard development must align with legal and ethical obligations towards Indigenous self-determination, reflected in the Constitution, Treaties, and international declarations including the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)**. This should include comprehensive engagement and co-development guided by the needs and expectations of Indigenous peoples themselves.

Thus, advancing the work of the MHSUH Collaborative and the Standardization Roadmap will require large-scale systems transformations across sectors, must ensure Indigenous was of knowing and doing are foundational, and must align with legal and ethical obligations towards Indigenous self-determination.

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APPENDIX A: FOCUS GROUP GUIDE

1. Current MHSUH Services	
Background: We would like to start by understanding your experiences, and/or the experiences of your family and community, with MHSUH services and systems as they currently exist.	
1.1	From your perspective, how is the current MHSUH system(s) performing when it comes to providing high quality services for Indigenous people? a. Have they met your needs or the needs of your family and community? Why or why not? b. What elements/programs/services would you say are worth keeping? What is working well?
1.2	Have you, your family member, or community member experienced any barriers or challenges when trying to access MHSUH services? (*Prompts: administrative barriers such as complicated forms, insurance, need for referrals, long wait times, Non-Insured Health Benefits (NIHB) limitations, distance to care, etc.)* a. Do you have any ideas about how those barriers could be reduced? *(Prompts: online services, services offered through primary care facilities, etc.)*
1.3	In your experience, are the current MHSUH services available to you, your family, and your community: a. culturally safe, and free from racism? b. trauma-informed? c. support healing and wellness from an Indigenous perspective?
2. Future MHSUH	
Background: We just talked about the current state of MHSUH services and systems. Now we would like to turn our attention to the future, to understand your hopes and goals for the future of MHSUH systems.	
2.1	We’re going to ask you to forget about limitations such as funding, location, or other barriers – and dream big! Can you describe what your ideal MHSUH systems would look like? a. Who is providing the services? What do the services look like? Where are the services located? What are the goals of the services? b. What needs to happen to make this a reality?

	c. What should stay the same?
2.2	In your ideal future world, what is the primary goal of the MHSUH healthcare systems? What are they trying to achieve? *(Prompt: healthy individuals, community-based healing, Indigenous people reconnecting to their culture, etc.)*
3. Service Standards	
Background: The collaborative is currently focused on understanding the current and desired state of agreed-upon rules, standards, or characteristics to ensure the quality and accessibility of MHSUH services and programs. This phase is meant to surface gaps and potential actions to address them in the future. This could include the future development of Indigenous-specific service standards. We’d like to take some time to hear your perspectives on that possibility.	
3.1	Do you see value in developing MHSUH service standards, including Indigenous-specific service standards? Why or why not?
3.2	Related to Indigenous-specific service standards, can you name what you see as the important pillars or broad themes that need to be included. *(Prompt: anti-racism and cultural safety, FN/I/M-specific holistic approaches, equitable and accessible services, etc.)*
3.3	In addition to establishing service standards, should that be desired by the folks engaged in this project, we know that standards must be implemented and continually evaluate and assess the quality and accessibility of MHSUH services and programs. a. How would knowing that a third-party reviewed and evaluated MHSUH programs or services affect your trust in them? b. What elements (staffing, structure, knowledge, accountability) would a third party have to possess or include to be able to meaningfully evaluate and assess Indigenous-specific MHSUH programs and services?
3.3	Beyond thinking about the potential utility of Indigenous-specific service standards, what are some potential actions or strategies that can advance the centering and/or integration of Indigenous knowledges and practices in MHSUH systems?
4. Closing	
4.1	Is there anything that we didn’t ask that you wanted to respond to?

APPENDIX B: CONSENT FORM

1. Declaration of Informed Consent, and Permission to Use Information

By signing below, I consent to participate in this discussion regarding the Standards Council of Canada's (SCC) *National Mental Health and Substance Use Health Standardization Collaborative – Indigenous Engagement* project.

I understand that this project is being conducted by the SCC, with the support of The Firelight Group (Firelight). The purpose of this engagement is to:

- Gather insights regarding what interventions or approaches are needed to improve the experiences and safety of Indigenous people accessing MHSUH services;
- Better understand the experiences of Indigenous peoples accessing MHSUH services in Canada, including strengths, barriers, and challenges within the current service landscape; and,
- Identify topics, themes, and areas of MHSUH that can benefit from standardization of service delivery, and how standardization may improve care outcomes.

.By signing below, I indicate my understanding that:

a) Participation is completely voluntary. I can choose to participate or NOT;

b) If I choose to particpate, I am free to NOT respond to questions that may be asked and I am free to end the engagement at any time I wish;

c) I consent to have my words and responses recorded in notes and using audio/video recording equipment;

d) I grant the SCC the right to use any intellectual property that I choose to share as a participant, for purposes specific to this work only, and not beyond that. Project leads will ask for my consent for any additional use beyond those purposes;

e) I pledge, with the researcher, to adhere to the Commitments of Engagement, throughout the engagement, as detailed on page 2.

For more information, please contact the project team by e-mail at kass.woods@thefirelightgroup.com.

______________________________	______________________________
Signature of participant	Date

2. Commitments of Engagement for Researchers and Participants

The Firelight Group seeks to ground our work in Indigenous values and methods including a commitment to relationality and accountability. To achieve this aim, we strive to be open, inviting, and authentic, while creating a safe space to share information, knowledge, and experiences. During engagements between researchers and participants, we expect both parties to treat one another with dignity, decency, and respect.

Researchers will commit to:

a) Ensuring consent is given by participants before conducting engagements and accept any requests to withdraw consent;
b) Accommodating participant requests as much as possible, to ensure privacy, confidentiality, and comfort;
c) Not rushing participants through the engagement, and giving adequate time to share their experiences through stories;
d) Actively listening, and showing compassion and empathy for the participant;
e) Ensuring the safeguarding of confidential or privately shared information;
f) Adhering to Firelight's Code of Conduct and relevant policies and guidelines.

Researchers and participants will commit to NOT:

a) Subjecting others to ANY form of intimidation, violence, abuse, or discrimination related to protected classes, such as race, colour, citizenship, national origin, religion, sexual orientation, age, physical size, culture, ethnicity, language, mental or physical ability, gender, gender identity and expression;
b) Making threats of violence, stalking, or intimidation; and
c) Making inappropriate physical contact or give unwanted sexual attention.

It is understood that the research process and topics covered may trigger anger, discomfort, or bring up trauma. It is important to hold space for these emotions, with compassion and empathy, though only to the point which is comfortable to the individual.

If any participant or researcher feels harassed, experiences, or witnesses the above or related behaviours, they can choose to end the engagement at any time.

By signing this document, the researcher and participant commit to the above.

______________________________	______________________________
Signature of participant	Signature of researcher

Date: _________________________

SCC CCN | Hill & Knowlton

NATIONAL CONSULTATION ON MENTAL HEALTH AND SUBSTANCE USE HEALTH STANDARDIZATION

WHAT WE LEARNED REPORT

MARCH 2024

Acknowledgements

The consultation team would like to express their deep gratitude to the hundreds of people from coast to coast to coast who shared their time, expertise and vision for improving the mental health and substance use health care system in Canada.

This work would not have been possible without people joining together, being open to listening and sharing and having honest discussions about the role that standards could play in advancing mental health and substance use health care in Canada. These conversations were not always easy, often asking about the most difficult parts of people’s wellness journeys.

We thank everyone who took part in this process for their trust, for welcoming us into their spaces and for sharing their time and stories with us.

Table of contents

Executive summary

The adverse impacts of the COVID-19 pandemic on the health and well-being of people in Canada has highlighted the need to address long-standing challenges in the delivery of mental health and substance use health (MHSUH) services and supports in Canada. An important step in that process is the development of national standards to formalize what people can expect in terms of the timeliness and quality of MHSUH services across the country. In March 2022, the federal government announced it would work with the Standards Council of Canada (SCC) and others to develop those standards. SCC then began a consultation process to gather insights on the challenges and opportunities of MHSUH standardization from people who directly access care, those who serve people who access care and those who research and develop programs and policy on care.

The first phase of consultations asked people who have accessed care or supported their loved ones in accessing care to share their perspectives and experiences. The second phase allowed other expert audiences to reflect on what was learned in the first phase and to focus on the role of standardization in implementing recommendations raised by people with living and lived expertise and other experts. In both phases, participants examined the current state of MHSUH care in Canada, outlined what an ideal future state would look like and proposed ways to get from here to there.

Current MHSUH services are seen as hard to understand and difficult to navigate. There is a lack of accurate and timely information about programs, the care they provide and the steps to be followed to access them. Challenges of navigation are exacerbated in times of crisis, with a significant lack of crisis response services and long wait times for services that do exist. Strict eligibility requirements for some services, such as having to refrain from using substances for a set time, are a significant barrier to access. Many services do not have enough resources to provide adequate levels of care, with staff experiencing added stress and burnout, sometimes to the point of leaving their profession. It can be particularly difficult to access services in remote, rural and northern communities. A trend toward increased privatization of services is creating a two-tiered system, where those with resources can access care while those without face more challenges.

Participants recognize that MHSUH care is complex but expressed widespread frustration that the various nodes of the system do not work together. There is little integration among services, inconsistency in how records are kept and shared, and a lack of coordination and communication, including with other systems of care and social services that have direct impacts on wellness. There are also inconsistencies in MHSUH programs across Canada, with varying eligibility criteria, discrepancies in length and types of programming, and differing philosophies around the involvement of families, friends or other loved ones in people’s wellness journeys.

MHSUH services are often designed to respond to those with the most acute need for care, but capacity challenges mean a significant portion of that care is addressed by medical systems already experiencing their own pressures and resources constraints. Some people with living or lived expertise fear the possible consequences of interacting with the healthcare system, where MHSUH challenges are sometimes overlooked completely or misdiagnosed and mistreated. There is also ongoing stigmatization of MHSUH care in institutions and society that can prevent services being established and providing compassionate care in certain communities.

Despite the overarching sentiment of an MHSUH care system that is dysfunctional and fragmented, participants highlighted several examples of positive stories of service providers doing amazing work with constrained resources. But they emphasized the system cannot rely on the ingenuity and goodwill of such providers and should instead build upon and implement solutions that have already been identified and championed.

A future MHSUH system should understand that MHSUH needs are as equally important to address as physical health needs. It should help people explore the underlying traumas and systemic factors that, for many, are the root cause of their MHSUH needs. It should centre and validate people's identities and experiences, providing flexible services to support people across a spectrum of strengths and needs with a variety of options for care, including one-on-one care, community-based programming, drop-in services and residential programs, and agnostic and spirituality-based care. Services should be expanded to communities that have been traditionally marginalized and underserved, including through the use of digital solutions.

A future system should provide continuity of care through the various stages of a person's wellness journey. There should be a navigator service to help people find and access appropriate services and supports, both for immediate crisis response situations and over the longer term. People should be supported and provided ongoing care after they leave a program or service, and information about a person's journey should be better recorded, stored and shared, including with that person, among the services they are accessing and, if the person consents, with their families or loved ones.

All of these services, including those that are privately offered, should be available at reduced or no cost to everyone in Canada through a public healthcare system that adequately funds high-quality care and supports staff. People should also be helped to access other critical wellness needs, including shorter-term ones such as a phone or computer with internet access and longer-term ones such as housing, employment or social welfare services.

Participants believe MHSUH standards would make accessing services a similar and positive experience across the country, guaranteeing a high quality of care and leading to overall better wellness outcomes. These standards should be developed and evaluated in collaboration with people with living and lived expertise, who should also be involved in program and service design and implementation. People seeking care should be able to provide feedback on their experiences with services against set standards in the system, including through a care ombudsperson who would take complaints, complete investigations and hold governments and services accountable against standards.

Standards would also serve as a benchmark from which to achieve the ideal future state of MHSUH care in Canada, providing active and proactive oversight, tracking, reporting and evaluation. Participants said funding in the future MHSUH system should be tied to meeting national standards regulating care and services but warned against increasing the administrative burden on programs and providers.

As important as these measures are, however, participants stressed that people die every day as a direct result of challenges in the current MHSUH system, as well as simultaneous crises such as the toxic drug crisis and the housing and affordability crisis. They called for urgent action to implement programs and policies to prevent deaths and further harms now so people can stay alive to benefit from an improved MHSUH system in the future.

Introduction

The Standards Council of Canada (SCC), in partnership with the National Mental Health and Substance Use Health Standardization Collaborative (the Collaborative), is embarking on the development of a Standardization Roadmap that will identify future opportunities to continue improving mental health and substance use health (MHSUH) service delivery and treatment outcomes across Canada.

Since 2022, Hill and Knowlton (H&K) has collaborated with SCC in undertaking a national consultation process to learn from diverse groups about the MHSUH needs, opportunities and standards that should inform the Standardization Roadmap.

This report summarizes the consultation process and the learnings that emerged from it.

Project context

In the aftermath of the COVID-19 pandemic, the Government of Canada announced in March 2022 that it would be working with SCC and interested parties and partners to develop national standards for MHSUH care. These standards are intended to provide an evidence-based, evidence-informed and experienced-informed frameworks for service delivery that people in Canada can rely on when they access care or support their loved ones in doing so.

Alongside this announcement, SCC launched the Collaborative, a forum that facilitates input from a diverse group of interested parties on MHSUH standardization. The Collaborative is responsible for developing the Standardization Roadmap, a document that will identify future opportunities to continue improving MHSUH service delivery and treatment outcomes across Canada.

As a parallel effort, H&K partnered with SCC to undertake a consultation process to garner further insights on the challenges and opportunities surrounding MHSUH standardization in Canada. This consultation process was national in scope and focused on understanding MHSUH care at the service, program, policy and systems levels, based on the diverse perspectives and experiences of the people who interact with it. At its foundation and as a first step, the process engaged the people directly impacted by MHSUH services and carried forward learnings from them to explore MHSUH programs and policies with other experts.

Engagement methodology

Goal, Objectives and Scope

The goal of the consultation process was to engage with stakeholders and people in Canada about their strengths, their needs and the future priorities of the Collaborative. The consultation team sought to better understand the current state and future expectations for MHSUH care and, broadly speaking, to increase awareness of the Collaborative and the work being done on MHSUH standardization.

In undertaking the process, the consultation team acknowledged that MHSUH covers many areas of people's care and life journeys. Recognizing that time and resources would not allow the team to learn from everyone on every aspect of MHSUH care, the process was shaped by the following scope established by SCC:

- Early identification, including workplaces, schools, family healthcare and social services; and
- Person-centred care, including intake, complex care, quality and culturally relevant care, and equitable and accessible points of care.

Guiding Principles and Practices

At the outset, H&K sought to establish a strong foundation for inclusive, supportive conversations that welcomed various perspectives and experiences of MHSUH care. The consultation team recognized that people would arrive at the consultation process with different starting points related to MHSUH care, some of which may be challenging and even traumatic based on their living and lived realities.

The consultation process adhered to the following principles, all of which derived from the principle of creating no additional harm:

- Participant-Centred: Valuing the lived and living wisdom and subject matter expertise inherent in every participant and partner at any or all levels of the process;
- Trauma-Informed: Ensuring engagement does not create additional harm and fostering opportunities for participants and partners to engage in a safe and supported manner;
- Accessible: Providing participants and partners with options to engage and sufficient information offered in advance, in plain language and in easy-to-digest formats;
- Flexible: Tailoring engagement based on needs and strengths and being open and responsive to what emerges that may require us to adapt; and
- Accountable: Being clear about our mutual expectations of one another in this process.

Another important component of inclusive, supportive engagement was centering and actioning diversity, equity and inclusion (DE&I), especially recognizing the diversity of audiences from whom the team sought to learn.

Throughout the process, the team committed to:

- Centering Indigenous knowledges and worldviews to ground the process in culture and resilience, where relevant and beneficial, and to address the ongoing impacts of settler colonial legacies;

- Weaving DE&I, anti-racism and decolonizing approaches into planning and implementation activities and recognizing that, without them, existing power dynamics could be reinforced;
- Learning from participants and partners to understand how barriers to participation differ by equity-deserving group;
- Developing tailored outreach and engagement strategies for equity-deserving groups that intentionally focus on the barriers they face and unique strengths they have to contribute;
- Offering more than one way to participate and partner, where relevant and feasible; and
- Taking a flexible, responsive approach by being open to feedback and adapting to address any gaps or opportunities that emerged.

The team envisioned the above tenets not only as guiding principles to be mindful of but as a practical ethos that informed the way in which engagement was planned and implemented.

Diverse Audiences

H&K set out to learn from all experts on MHSUH care, which included people who directly access care, people who serve those who access care, people who research and develop programs and policy on care, and the intersections of these overlapping roles. The consultation team recognized that people “wear multiple hats” in the MHSUH space and remained cognizant of and curious about the intersections of people’s roles and experiences when they arrived at engagement.

On the whole, H&K engaged the following audiences throughout the consultation process:

- People with living and lived expertise;
- Service providers;
- Civil society organizations;
- Researchers and academics;
- Policy and program developers; and
- Pan-Canadian health organizations.

Amidst these audiences, a priority for the consultation team was learning from individuals and communities who have been historically marginalized in conversations on MHSUH care, which could include equity-deserving groups such as racialized people, people with disabilities, people who are unhoused and the intersectional identities that all of these groups carry and embody. It was similarly important for the team to remain curious and draw on the strengths these groups bring to engagement - strengths that exist and persist amidst the harms, barriers and inequities they face when accessing MHSUH care.

While this consultation process sought to engage equity-deserving groups, a separate process was undertaken by another consultation team to learn exclusively from Indigenous peoples and communities.

Phased Approach

Considering the diverse groups invited to participate in the consultation process, H&K undertook a phased approach to engagement that welcomed various perspectives and experiences of MHSUH care in Canada. At its foundation, this approach sought to learn from people with living and lived expertise on their perspectives and experiences of MHSUH services and to use the learnings gathered as a starting point for subsequent conversations with other experts on MHSUH care.

Phase 0: Learning about the MHSUH Landscape - November 2022 to September 2023

To prepare for learning from people with living and lived expertise, H&K completed secondary background research to better understand prevalent MHSUH trends and the distinct and disproportionate impacts these issues have on different equity-deserving groups.

The consultation team completed desktop research to establish an evidence-based starting point for key groups whose perspectives and experiences were important to understanding the landscape surrounding MHSUH care. This effort focused on:

- Demographic research for all provinces/territories (P/Ts) and their largest cities;
- Prevalence research on MHSUH and suicide in all P/Ts; and
- Research on health system considerations, such as long wait times or barriers to accessing care.

To complement the research process, the team engaged in learning and capacity building activities in order to equip them to convene inclusive, supportive conversations on MHSUH care. The team undertook both structured and self-directed learning on trauma-informed engagement and person-centred language and was supported throughout these activities and the broader consultation process by the Community Addictions Peer Support Association.

The team endeavoured to remain transparent in undertaking capacity building as a means of setting a strong foundation for engaging people with living and lived expertise. They were mindful of the importance of bringing SCC, the Collaborative and its Steering Committee along in their journey of research and learning. The team delivered several presentations to the Steering Committee to update it on their progress and, in the summer of 2023, delivered a series of information sessions for members of the Collaborative to hear about the process and future opportunities for getting involved in it.

The team also practised transparency by being open to discussing the learning journey members were undertaking on MHSUH care. As a result of this openness, a participant in one of the engagement sessions encouraged the team to share candidly about their learnings as engagement practitioners.

The most pertinent and meaningful learnings are as follows:

- Engage with people, first and foremost, as human beings with the same care, consideration and empathy you would with anyone else. Amidst this focus on shared humanity, be mindful of the power that engagement practitioners carry in convening spaces on challenging topics, especially if those practitioners do not have living or lived expertise.
- Come to engagement fully prepared but also take the lead of the people participating in the conversations. Starting where they are at means yielding to their agency and expertise and recognizing, with deep humility, that there is something to learn in every interaction.
- Making mistakes or getting something wrong is part of the learning process, as long as it does not create additional harm for people. Remain open to feedback about the way in which engagement is being undertaken just as much as seeking to learn about perspectives and experiences on the subject at hand.
- Opening spaces for people to discuss the exact systems that harmed them means support must be made available and tailored to individual strengths and needs. Offer a variety of supports,

including compensation, language supports, counselling supports and more, and ask what works best for people in a given moment.
- Understand the accountability that engagement practitioners have in validating what was learned in the conversations and carrying those insights forward to decision-makers or people with the power to create change.

Phase 1: Learning about MHSUH Services - October 2023 to January 2024

After the research and learning phase was underway, H&K proceeded with planning and implementing two phases of engagement.

The first phase was rooted in the understanding that the consultation team needed to ground conversations on MHSUH care in the perspectives and experiences of people who have accessed care or supported their loved ones in doing so. As such, the first phase exclusively engaged people with living and lived expertise on their perspectives and experiences of MHSUH services. This phase asked about perspectives and experiences of MHSUH services in three areas:

- Current state of services, including services as they exist now and what it has been like accessing them or supporting loved ones in accessing them;
- Future state of services, including imagining the ideal services of the future and what they might look and feel like; and
- How to get there, including the steps or actions required to move from the current state to the future state.

In commencing the first phase, the consultation team was attentive to building on the long-standing work already being done in the MHSUH space and being least disruptive in this process by identifying the places where people were already having these conversations. The team took the approach of inviting organizations that are led by or that serve people with living and lived expertise to partner in the process based on their interest, availability and capacity.

The team offered an invitation to partner with organizations within and outside of the Collaborative. They also completed research and facilitated conversations with existing partners to fill gaps in organizations and the people they serve that may operate outside of the Collaborative. A wide variety of individuals and organizations were invited to partner, including community organizations (such as harm reduction centres) and private care facilities (such as residential care services). The team worked in collaboration with partnering individuals and organizations to determine whom to invite to engagement sessions and how best to ensure that people were supported in engaging on the subject matter.

The team was fortunate to have partnered with many individuals and organizations that supported them in learning from a diversity of people with living and lived expertise across the country. In total, the team:

- Learned from 150+ people;
- Convened 18 focus groups and 18 one-on-one discussions;
- Facilitated virtual and in-person sessions based on the preferences of each group;
- Co-hosted sessions with partners nationally and in Ontario, Québec, Nova Scotia, New Brunswick, Prince Edward Island, Alberta, British Columbia and the Yukon; and
- Saw representation at sessions from the following equity-deserving groups:
    - Youth;

  - Women;
  - Newcomers;
  - Caregivers;
  - Racialized people;
  - Older adults;
  - People with disabilities;
  - People with low incomes;
  - People who are unhoused;
  - People with experiences of criminalization; and
  - 2SLGBTQIA+ people.[1]

It is important to recognize that not everyone had the chance to come to the table for this phase of consultation. One of the realities highlighted by participants is that existing MHSUH services are only built to support people at the more acute end of the spectrum of wellness. As a result, partner individuals and organizations in this phase largely served people who have or have had acute experiences of MHSUH services, although the team was aware that strengths, needs and care are experienced in many different ways along the spectrum that are not always acute.

It is also important to note that the team was asked on several occasions how they would be treating the insights and stories collected, especially given the reality that people have often been over-consulted with little appreciation or accountability in what happens after the consultation process. In this vein, honesty around how information would be collected, compiled and used was important to participants and was critical in building a sense of trust with the team. The team committed to ensuring participant perspectives and experiences were accurately reflected through drafting, sharing back discussion summaries after each engagement session and, at the end of the process, communicating the key learnings and themes back in this report.

The team is grateful to have learned from many people who generously shared their perspectives and experiences of the current state of MHSUH services, what they dream for the future of these services and what is required to push care forward. These learnings served as the foundation for the team moving into the second and final phase of engagement.

Phase 2: Learning about MHSUH Programs and Policies - February 2024

Grounded in the insights gathered from the first phase of consultation, the second phase used what was learned from people with living and lived expertise to carry forward conversations on MHSUH programs and policies.

For this phase, H&K hosted a national convening event for other expert audiences, including policymakers, service providers, non-governmental organizations, pan-Canadian health organizations and people with living and lived expertise serving in these capacities. These audiences were invited to reflect on what was learned in the first phase on MHSUH services and to use those insights to take stock of the current state of MHSUH programs and policies, imagine the future state of programs and policies and discuss how to move from the current state to the future state. The conversations also focused on

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[1] Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, Asexual and other affirmative ways in which people choose to self-identify.

the role of standardization in implementing the recommendations raised by people with living and lived expertise and other experts.

The consultation team hosted the National Mental Health and Substance Use Health Summit on February 21, 2024. Individual and organizational partners from the first phase of consultation, as well as other experts within the broader Collaborative, were invited to participate in the full-day, conference-style event held virtually over Zoom. The summit saw more than 75 experts attend and participate in the conversations, with 10+ experts completing an accompanying survey asking for further reflections. All experts were supported in their participation through the use of breakout rooms, counselling supports, language interpretation and honoraria.

What we learned

The consultation team wanted to open this section of the report with important observations that emerged from the collection of learnings gathered from the consultation process, starting with the devastating impacts that have been experienced by people who have accessed and are looking to access the MHSUH system.

Across the country, participants stressed the urgent need for change in the MHSUH space. Lives are being unnecessarily lost every day, something participants expressed having become too familiar with. There are compounding crises, from a mental health and loneliness crisis, to a toxic drug supply crisis, to a housing and affordability crisis. Taken together, these crises have significant impacts on people's health and wellness. In that light, people called for immediate action to address and ameliorate these crises and their devastating impacts.

It was also emphasized that the COVID-19 pandemic has had significant and negative impacts on mental health and substance use health across Canada, exacerbating the demand for MHSUH services everywhere. Participants noted, however, that investments in MHSUH care have not kept up with this rising demand. To illustrate this point, one participant provided the following anecdote:

> **“There are two snowballs rolling down a hill. One of them is a little bigger and a little further down the hill. That one is the MHSUH care crisis. The other one, the smaller one, is the MHSUH services that exist to respond to those care needs. While the number of services has increased over the years, the first snowball - representing the MHSUH crisis - is still bigger and is rolling down the hill first. The smaller one cannot catch up to the bigger one unless external force is enacted upon it.”**

Participants in the second phase of consultation said they have been having these conversations for decades. There is a sense of frustration that, while community organizations, service providers and people with lived and living expertise know what the solutions are, there still has not been any change. From their perspective, it is a question of willingness on the part of the MHSUH system to allow enough flexibility and capacity to let important changes be made.

Current State of Mental Health and Substance Use Health Care

The conversations convened in this consultation process started by asking people with living and lived expertise about their perspectives and experiences in accessing MHSUH services, including what has worked well, what has not worked well and everything in between. Participants discussed MHSUH services as they are today, sharing their perspectives and experiences with the services and programs that they have interacted with or have supported their loved ones in interacting with.

Navigating Services

Participants in the first phase of consultation said MHSUH services are hard to understand and hard to navigate. One of the most important challenges is trying to find accurate and timely information about which programs exist, what care they provide and what steps are required to access them. Navigating services, especially for someone experiencing distress or crisis, is often an insurmountable task, with several participants adding that this challenge is likely to stop a significant number of people who could benefit from services.

There is a significant lack of centralized and up-to-date information on services that exist across the country, including in specific regions, and across different stages of life. This gap forces individuals to become navigators, requiring them to do the groundwork of researching and connecting with services for themselves when they may not be in a place that is safe and comfortable. Several participants added they feel the need to become their own advocate, pushing back against poor advice or protecting themselves from harmful experiences. It was stressed that people seeking services do not hope to become advocates for themselves or for systemic change but that the dysfunction of services mobilizes them out of necessity.

Participants shared that, even when someone is able to start navigating services, they are confronted with being at the "wrong door," meaning the service may not address their situation or there are certain criteria that make them ineligible for access. In other cases, participants found themselves being perceived as "not unwell enough" to access services, creating additional barriers for people who have just reached out to services, often without direction on where to go next.

"Because I could be a presentable version of mentally ****ed, they took me seriously."

Alongside the challenges of navigation, participants found they had little say over the decisions made surrounding their care, especially in the case of wanting to push back against healthcare professionals in the medical system. This lack of involvement and collaboration in their own wellness journeys was a significant challenge and barrier for many participants. It also illustrates a significant power imbalance between professionals and individuals accessing care, creating a wall between those providing services and those seeking services. In cases where this imbalance causes harms, it can feel even more impossible for individuals to navigate systems of accountability for those professionals.

The challenges of navigation are exacerbated in times of crisis. There is a significant lack of crisis response services, and programs that exist often have long wait times and are unable to respond immediately. In almost every conversation, participants said that someone reaching out for care – especially someone reaching out for detox, help with substance use challenges or someone thinking of suicide – has a small window in which they are willing and able to receive help. If services are not able to respond within that window, there is a risk that the person is no longer in a place where they are willing to receive care.

**"In mental health and substance use health, we're up against a lot.
This work is extremely impactful and could change things in the long term.
Helping people navigate the system is not as impactful."**

In several conversations, participants discussed eligibility criteria as a significant barrier to accessing services. In many cases, participants said some services would not admit people unless they refrained from using substances for a set time prior to intake. In other cases, some services focused on substance use health would not coordinate with mental health providers to offer participants space to talk about the link between their challenges, needs and strengths. Even though mental health and substance use health are closely intertwined, participants noted that having joint services can present an increased risk, especially in cases where individuals who have worked to abstain from substances are placed in an environment where there is a chance that those substances are available. Participants said there is a need for dedicated mental health and dedicated substance use health care services, while also creating space for people to access either, both or whatever combination will get them closer to their wellness goals.

In the second phase of consultation, service providers, policymakers and thought leaders added there has been a trend toward increased privatization in services that is creating a two-tiered system of access. It is possible to access timely, responsive and flexible services at any time as long as you can pay for it yourself. This tiering creates an inherent inequality, where those with the resources to do so are able to access care, while those who do not have the resources continue to experience challenges and barriers constraining access.

Communication and Collaboration

There was a recognition in the first and second phases of consultation that MHSUH care is a complex issue with governments, organizations, businesses and other stakeholders playing their own roles. In some regions, there is structured care in place, whereas care in other regions is housed under the umbrella of the broader health system. These discrepancies increase the level of complexity and the number of stakeholders involved in delivering care.

While participants understand that the system is complicated and cannot be easy to manage, there was widespread frustration that the various nodes of the system – including healthcare providers, MHSUH care providers, community health organizations and other social service systems – do not work together. This lack of coordination exacerbates the challenges experienced by people seeking care, as being connected to one service does not necessarily mean it will lead toward connection with other services.

> **“We don’t need to reinvent the wheel, but we have to make it simpler because the wheel is very complicated”.**

Relatedly, there is little integration between services. When someone is able to access a service, or even when a referral has been made, it is not possible to share that information with other services. Individuals are left to repeat the same intake process, which can often include rehashing traumatic experiences despite that information having been collected previously. Several participants noted this lack of integration can have negative impacts on people’s ability to follow and engage in programs, as it fosters fear of what will happen when programs end.

Participants discussed inconsistency in how records are kept and shared, with every service creating its own record with intake and care information but not making this information available to other service providers, to the health care system or to the individuals themselves. While restrictions on information dissemination prevent seamless navigation, participants were also aware of the individual and organizational risks related to sharing sensitive health information. As a separate note, participants were concerned that information collected by service providers could reflect stigmatizing views that lead to harmful decisions made by healthcare professionals.

Participants also discussed how the lack of coordination and communication between nodes extends beyond the MHSUH and medical system and includes other systems of care and social services that have direct impacts on wellness. These systems include housing, child welfare, youth services and correctional services, all of which are touchpoints that can be leveraged to connect people accessing other services to MHSUH services in an integrated manner.

Program Responsiveness

Participants in the first phase of consultation discussed the responsiveness of services, how they are often not able to provide adequate levels of care despite good intentions and how these challenges are tied directly to the capacity of service organizations.

Many services do not have enough resources to address the amount of MHSUH needs in their communities and, as these needs continue to grow, the resources they do have are being stretched thinner and thinner. Participants talked at length about how, in most cases, the challenges they experience are systematic challenges that persist despite the best efforts of organizations and their staff. To that end, many staff are experiencing added stress and burnout themselves, sometimes to the point of leaving their professions. Adequate systems of care do not exist for those who work within organizations, as service providers themselves experience the same challenges in trying to access services.

Participants added that there are significant wait times to access services across the country, no matter the type of service. For example, detox beds can take weeks to access, residential substance use health programs can take years, and mental health counsellors in cities are no longer offering waiting lists because those lists have become so long. Wait times are not only a barrier but can also lead someone to turn away from accessing services entirely, leaving people feeling like there are no options.

Participants said that mental health service providers, such as counsellors or psychotherapists, rarely provide information on their availability, including whether they are taking on new clients. Similarly, the significant delay in accessing substance use health services, especially for long-term programs, leaves people at a higher risk of dying before they are able to access a spot. People are left with the option of going to either detox programs or a hospital emergency room where, in both cases, there are often additional barriers, wait times or active stigmatization that makes accessing services more harmful than helpful.

“The system is what put me in the hospital.”

Another insight that surfaced in nearly every discussion was the gaps that persist in crisis or immediate response services for mental health needs. These services are inconsistent across the country and often already overstretched. It is not uncommon to call a crisis response line only to be put on hold or to find yourself listening to an automated response telling you to try phoning again. In most cases, the only reliable emergency response line that can be called is 911, which will always include a police response. Police are not adequately trained in de-escalation or in approaching situations with compassion and care, which can put racialized people, people in crisis, people with disabilities and others at risk.

The ability for services to respond to needs depends on where you live. In some regions, there is a selection of services that might be tailored to specific needs, identities or experiences. In other regions, there are sometimes only one or two services that follow a one-size-fits-all approach. In particular, when looking at remote, rural and northern communities, it can be very difficult to access services. There may be no services at all in a community, or some services may only be available on a rotational basis. This rotation can make it hard for services to follow through on care and can render adequate aftercare nearly impossible. In some cases, individuals are required to leave their homes to attend services in other communities, which can increase the risk of compromising their wellness once they return to the same environment from which they required support. These challenges are exacerbated in communities that may have social or physical infrastructure gaps that limit the availability of services.

There were also several conversations around the importance of services that are reflective of culture and rooted in community. While these strength-based programs have had positive impacts, especially for racialized communities and linguistic-minority communities, they are often only found in large cities. Services reflective of culture, language and identity were highlighted as an effective part of the MHSUH system, as they are better positioned to meet people where they are at and consider the nuances of their individual and collective experiences. There are several examples of these services across the country, from targeted culture-based or language-based services to casual drop-in centres accessible to everyone.

Several participants noted that, when services are not reflective of people's strengths and needs, practitioners should take part in continuous learning to counteract knowledge that may be considered out of date. For example, some service providers may hold outdated views on identity and sexuality that can create harms for 2SLGBTQ+ people accessing their programs. Another example cited focused on substance use health services, where there has been more research and resources created on some substances compared to others. Participants in New Brunswick noted that their province has incredible services in place to support someone in addressing challenges related to alcohol use, but it does not have the same services available to support someone using opioids.

Participants in the second phase of consultation reiterated many of the points raised by those who took part in the first phase, adding some nuance to the perspectives and experiences of people working as service providers or health practitioners. According to them, the lack of capacity, resources and supports in organizations creates little job security and leads to the harms that providers experience. In some cases, students who are inspired to enter the field feel burnt out shortly after starting. Although these students leave their training full of excitement to provide person-centred care, the realities of working in the field leave some feeling disillusioned and unable to do the work they had set out to do.

Program Structure

Throughout the first phase, participants discussed the structure of MHSUH services, including a lack of consistency in approach and eligibility across programs.

They highlighted the inconsistencies in MHSUH programs across Canada, including discrepancies in length and type of programming available. They also discussed the importance of recognizing the different needs of people seeking to access mental health services separate from or in tandem with substance use health services. Currently, a spectrum of services to address mental health needs, substance use health needs or any combination of both does not exist. While better coordination between the two is required, there remains a distinct need for dedicated mental health services and substance use health services.

Participants explained that MHSUH services have varying eligibility criteria and wellness outcomes required to be met before leaving programs, which serve as barriers to someone seeking care or achieving their own wellness goals. These include limited catchment areas for programs, residential-based programming that could take people away from their homes, and programs that require people to refrain from using substances on their own accord.

Other barriers more systematic in nature include a person's location and ability to access programs in their area and possible additional costs to access programs, such as transportation, accommodation and childcare, especially if someone is entering longer-term programs. One participant noted there are several low-cost or free programs in British Columbia that are theoretically accessible, but people risk losing their homes if they attend because the duration of programs would mean they must leave their job and would not be able to afford to pay rent.

Beyond the point of access, there are contradictions in philosophies and approaches across MHSUH services that create a complicated landscape for service users. It can be challenging for individuals to find services that are reflective of their specific strengths and needs. Even when services are located, they can sometimes conflict with policies established either by organizations or governments. A key example offered by participants is inconsistent philosophies around the involvement of families, friends or other loved ones in people's wellness journeys, especially from the perspective of including loved ones in information-sharing and decision-making. While some participants appreciated the stringent restrictions on the ability of loved ones to access information and decisions, others said existing privacy legislation is too rigid and excludes loved ones to the detriment of people seeking care.

Another example of inconsistent philosophies relates to harm reduction efforts, including the availability of a safe supply, overdose prevention sites and drug-testing facilities. The approach to substance use health in communities, including the opioid and toxic drug crisis, varies substantially across Canada. For example, while NARCAN Nasal Spray is available for free from pharmacies to any resident in Ontario, access to it in British Columbia is more challenging or nearly non-existent due to cost barriers. In Alberta, the province is focusing solely on a recovery model that does not make space for any harm reduction efforts to take place there. Many participants said MHSUH services must prioritize keeping people alive and that harm reduction is an important tool for providing life-saving services. Other participants said all tools, including recovery and harm reduction, should be seen as multiple avenues someone can choose to reach their self-defined wellness goals.

Participants in the second phase reiterated that MHSUH services are often designed to respond to those who have the most acute need for care, with many getting turned away for being perceived as "not unwell enough" to justify providing access. There are little to no services in place to support those who want to explore bettering their mental health or who want to better understand their relationship with substances. As a result, MHSUH challenges escalate to the point where they require advanced care and investment to address them, rather than investing in and developing services aimed at prevention and holistic wellness.

"Street, treat, repeat is ineffective."

MHSUH and the Medical System

The relationship among mental health, substance use health and physical health systems was brought up at every session in both phases of consultation.

As a result of the capacity challenges mentioned in previous sections, a significant portion of MHSUH needs is directed to and addressed by the medical system, including hospitals, doctors, nurses and community health organizations. Participants noted the medical system is also experiencing significant capacity pressures and resources constraints, especially coming out of the COVID-19 pandemic. The result is widespread sentiment that MHSUH needs are not taken seriously in the medical field, which causes people to distrust and avoid interacting with primary healthcare settings, even when it may be critical to do so.

Another dimension to the distrust is that people fear the possible consequences from an interaction with the healthcare system. Participants shared deeply traumatic experiences that occurred in hospitals, clinics or other healthcare settings where medical staff treated them badly or where they were turned away when seeking medical treatment. There remains a large gap in knowledge in the healthcare system about MHSUH care and about how to approach people with compassion, how to listen to and engage with people, and how to better understand the lived expertise of people.

Participants noted that healthcare professionals often take a medical approach to addressing presenting issues, meaning MHSUH challenges are sometimes overlooked entirely or misdiagnosed and mistreated for a physical ailment that does not actually exist. Participants shared on more than one occasion the harmful side effects that have resulted from incorrect or inappropriate diagnosis or care. When these incidents occur, power imbalances in the system can hinder someone from seeking further care, advice or remediation. In these cases, it can be nearly impossible to navigate tribunals and other patient advocacy organizations to address the harms that result from improper care. The power dynamic present also means that, in some cases, other providers or justice-oriented organizations are more likely to side with medical professionals over the individual who has been harmed.

Underlying many of the issues raised is that healthcare professionals can hold outdated or harmful views related to MHSUH care. In some cases, people feel that medical professionals have been dismissive of MHSUH concerns, causing them to feel further alienated and sowing further distrust in the healthcare system. Some medical professionals approach substance use health as a strictly medical or seemingly moral issue, telling people to abstain from using substances as the only option that exists in their wellness journeys. Other professionals can have outdated views on 2SLGBTQ+ identities and rights, locating a person's sexual or gender identities as a "problem" to fix rather than identifying the root causes of MHSUH challenges or barriers.

Stigma and Society

Participants in the first phase of consultation said the most pervasive issue MHSUH services face is the ongoing stigmatization of MHSUH care in institutions and society. They expressed feeling like they were not being taken seriously and that their concerns or feedback were easily dismissed by healthcare professionals, service providers and everyday people. There are several ways in which even simple things such as the language people choose to use can make others feel dismissed and "othered." These choices can have detrimental impacts on someone's wellness.

There is a double standard around MHSUH care compared to physical health care. For example, if someone breaks their leg, it is widely understood they should seek medical care from their nearest hospital and that this hospital has evidence-based procedures to ensure the person has the best possible outcomes for their ailment. If someone approaches the same hospital with a mental health concern, the approach taken next can vary immensely, from providing care to calling the police or placing the person in custody. Participants felt they needed to present themselves as being "unwell enough" to be taken seriously, which in some cases included choosing to inflict additional harm on themselves to be able to access services. The stigmatization of substance use is particularly pervasive, leading to people who use drugs being denied or delayed care to the point where they die waiting to access substance use health services or basic physical health services.

"I felt like I needed to harm myself more to get services, to be taken seriously."

One of the biggest obstacles facing harm reduction services for substance use health is a sense of fear, rooted in stigmatization, that prevents those services from taking root in certain communities. Participants across the country talked about how the services they have accessed face NIMBY (Not in My Back Yard) attitudes toward their establishment or expansion. These attitudes relegate many services to parts of cities that are far removed from where people live, where people spend time and where people may be trying to seek other integrated services. In Prince Edward Island, for example, there are tense and ongoing conflicts between service organizations and neighbouring communities that affect service providers and have included violent outbursts toward people seeking care in the area.

Participants said societal stigma remains prevalent across the country. In many cases, society views MHSUH situations through a lens that sees people as "broken" and needing to be "fixed," with the problem located in the individuals seeking care rather than the institutions and systems that have erected barriers to accessing care and created gaps in providing care. Participants also discussed how the stigmatization of MHSUH challenges interacts with the stigma experienced by communities because of identity factors such as race, culture, class, ability, gender, sexuality or age. MHSUH care can be experienced through as many different lenses as there are individual people, resulting in diverse intersections of stigmatization that may inhibit people from accessing services in unique ways.

That said, participants shared that the public discourse around mental health has, in fact, improved due to people having more conversations and normalizing those conversations in broader society. Unfortunately, the same cannot be said around the stigma related to substance use health. If anything, the stigmatization of substance use health challenges has increased, leading to more negative health outcomes for people who use drugs. One factor that could explain this persisting stigma is the negative judgments and assumptions that come with people self-identifying as having living or lived expertise. People are often hesitant to self-identify largely because of the fear of being judged or other consequences that may emerge from their self-disclosure in professional settings. Their lack of representation in care settings leads to stigma that goes unchallenged, which further discourages people from providing and receiving care from these same services.

Participants in the second phase agreed that, despite ongoing awareness and education efforts across the country, MHSUH challenges are still deeply stigmatized. They also agreed that, while strides have been made towards destigmatizing mental health, substance use health care still faces significant stigma. In some cases, stigma can be better understood as discrimination against those experiencing MHSUH challenges. This shift in perspective allows people to see the ways in which stigma negatively impacts individuals, families and communities.

Stories of Success

While the overarching sentiment on the current state of MHSUH services is that of a dysfunctional and fragmented system, participants highlighted numerous examples of positive stories from service providers doing amazing work within a context of often limited or constrained resources.

Some examples of service providers going above and beyond included offering pro-bono services after funding had lapsed or helping people outside their work hours to connect them to services. Although there are several of these positive examples, participants emphasized that the system cannot rely on the goodwill of service providers, especially when they themselves are facing similar challenges relating to affordability, access to housing and finding access to their own MHSUH care.

Participants across the country shared success stories that are worth cataloguing here:

- In Québec, advances in regional coordination of social services, including MHSUH services, has led to the creation of centralized, up-to-date inventories of available resources and estimated wait times.
- In New Brunswick, community-based organizations have partnered with healthcare providers, including locally owned pharmacies, to make substance use health services more accessible.
- In British Columbia, some hospitals have begun integrating MHSUH services with medical services, using hospital spaces to host monthly drop-in meetings related to various physical health, mental health and substance use health topics.
- In Prince Edward Island, community-based and government-based MHSUH services have begun the conversation around "hubbing" care across the province, which would create a province-wide inventory of services with up-to-date availabilities and information on how to access programs or various funding streams supporting those programs.
- In the Yukon, the COVID-19 pandemic opened the door to an increased availability of virtual care services, including MHSUH services, which has increased the accessibility of services in some remote, rural and northern communities.
- In Ontario, a "community ambassador" model, originally employed as a tool to inform communities about COVID-19 measures and vaccination efforts, was highlighted as a solution that could be leveraged to better equip communities to address MHSUH challenges. The program hired people who represented a wide diversity of communities in the province, including racialized communities, linguistic minority communities and people of different ages living in various regions, to communicate through channels familiar with their communities about services that were available.

Participants viewed these and other constructive examples as the starting point from which to strengthen and even reimagine the MHSUH system in Canada. It was highlighted by several participants that those who provide and receive care every day already know what the solutions are and are working to improve the system and implement best practices, which is why they believe that change must come from the government level.

"It's time to take responsibility."

Future State of Mental Health and Substance Use Health Care

After finishing discussions on the current state of MHSUH services, the conversations at the engagement sessions moved toward an exploration of what the future state of MHSUH services could look like. Participants were asked what the ideal system that is accessible, responsive to people's identities and experiences and made people feel truly seen and cared for would look and feel like.

<u>Evidence-Based Approaches</u>

Participants in both phases of the consultation process highlighted that the evidence to support calls for person-centred, trauma-informed and community-based programming in the MHSUH space already exists. The challenge is not in identifying solutions that meet people's strengths and needs but more a question of implementing the solutions that have already been championed by people with living and lived expertise, service providers and other leaders in the space.

"The evidence is already there - so act on it."

The most effective and inclusive solutions include providing person-centred and trauma-informed services, increasing access to these services and creating flexible and community-based programs that are reflective of the people they serve. There is also a mountain of evidence supporting approaches that keep people alive long enough to access services, including crisis response services, overdose prevention sites, and accessible testing for substances. Several participants noted evidence generated in other countries, including research into the decriminalization of substances in Portugal, and encouraged Canada to draw from the learnings and best practices that have emerged from these countries.

There are some cases where robust evidence and case studies may not exist, such as in the role of identity- and community-based programming in Canada. Additional research is needed to identify the learnings and best practices that are crucial to program and service development, especially research that is rooted in a wider range of communities across the country.

There is also room for the implementation of national strategies on several key components of the MHSUH system. While it was recognized that each province and territory might approach service provision differently and that other communities, including racialized communities and linguistic minority communities, may have their own approaches to addressing specific needs, there was broad agreement that the federal government has a role to play in coordinating services among jurisdictions and in setting national standards. Participants generally agreed that the standardization of MHSUH care could go a long way to ensuring a high quality of services across the country.

Trauma-Informed Services

Reflecting the robust evidence base that exists and relying on living and lived expertise, participants in both phases said the future state of MHSUH care will be trauma-informed, providing services that can help people explore the underlying traumas and other experiences that, for many, serve as the root cause of their MHSUH needs. Trauma-informed care is also able to recognize the inherent strengths within people and communities and uses these strengths as a tool to support and empower people within their MHSUH journeys.

The future state will understand MHSUH needs as health matters that are equally important to address as a broken leg or a cancer diagnosis and are addressed with as much urgency as physical health matters currently are. At the foundation, the future state will have eliminated the stigma around MHSUH needs and, just as with any physical ailment, will identify and address the root causes of these needs, including the underlying and often systemic issues at play rather than trying to locate blame and problematize the person seeking care.

**"Being respected is helpful. Being heard is helpful.
I can be ill in front of you and not thinking that you think less of me."**

Participants reiterated that the system will not be able to implement a trauma-informed approach without being led by people with living and lived expertise, as they are the experts who understand how best to design services to target the root traumatic causes experienced by their communities. Participants added that developing trauma-informed services creates opportunities to invest in community-building projects created and led by people with living and lived expertise that enrich the fabric of community-oriented services that exist in Canada.

There are several other philosophies, approaches and practices that can be featured within a trauma-informed MHSUH system. Many of these are elaborated in the following sections which describe other elements of the future state of MHSUH care.

Person-Centred Services

Alongside the need for trauma-informed services, there was strong agreement that the future of MHSUH care must be person-centred. This philosophy of care takes shape in many ways, from approaches that centre and validate people's identities and experiences to providing flexible services that offer options to support people across a spectrum of strengths and needs. Participants tended to agree that the one-size-fits-all approach used to provide MHSUH care in the past decades has failed and that the alternative is to create a system that can size-to-fit various needs and realities.

On that note, participants emphasized that the future state of MHSUH care must be rooted in flexibility and understanding. There should be an understanding that people experience challenges while seeking care – even after they have started working with service providers – and those challenges should not automatically lead to the person being dropped from programs. For example, in substance-free living programs, shared spaces might be places where others are put at risk if someone who had resumed substance use was welcomed back into facilities. In this case, that person should not be turned away from programs entirely but referred to initial or alternative services with more appropriate trajectories that could be decided in consultation with them. Services in the future state should create a web-like support structure so that, no matter the particular circumstances of someone's journey, there is a right route to access the right services.

Throughout the consultation process, participants discussed the importance of a future state that is able to provide people with a variety of options for care rather than prescribing specific options without any input or collaboration from them. There are many types of programs containing options that reflect different philosophies, approaches and structures. This presents an opportunity to diversify and tailor services in a way that reaches more people and their unique strengths and needs. Reflecting this landscape, participants said there is space in the future state for both the recovery model and the harm reduction model, for one-on-one care and community-based programming, for drop-in services and residential programs, and for agnostic and spirituality-based care. The existence of one service does not preclude the existence of others. In fact, participants believe that having multiple streams that all orient toward wellness gives people the best possible chance to find the right combination of services.

Participants highlighted that having a diversity of philosophies, approaches and structures, rooted in individual and collective identities and experiences, is another way of expanding services to communities that have been traditionally marginalized and underserved. The ability to access services in your language of choice, offered by members of your own community who can understand your worldviews, perspectives and struggles, is immensely valuable. These services could also include an element of simply offering time for people to spend with other members of their community in a safe social environment. Participants added these types of services would be particularly beneficial for equity-deserving communities, including newcomers, racialized communities, linguistic minority communities and 2SLGBQ+ communities, as many people from these communities can find it extremely difficult to locate services that are reflective of their identities and experiences.

In addition to having services tailored to meet the strengths and needs of specific communities, participants said programs should be customized for different genders and for various age groups. While many programs target a wide range of people, there are cases where accessing support and resources is more conducive in an environment alongside other people of your gender or age group. Youth participants across the country said there is a significant gap in youth-oriented programming, especially outside of urban centres. In the future state, youth-focused programs, and programs tailored to the distinct needs of men and women, would be a part of the various options available to someone seeking care.

An added dimension is that person-centred care requires centring compassion and understanding in services and sometimes approaching wellness in different ways depending on the strengths and needs of the person seeking care. One example is the inclusion of family members or loved ones in a person's journey. In some cases, involving family can be detrimental to a person's wellness because of past experiences of neglect, abuse or trauma. In other cases, involving family can help them create structures of wellness that endure after programs have ended. Including family or loved ones requires policies and procedures that allow programs to check-in and re-evaluate limitations around information sharing and family involvement, always in collaboration with the person seeking care, and always ensuring the person's rights are prioritized.

"Bring your compassion."

Participants also said person-centred care means helping people access other needs that are critical to their wellness, including longer-term goals such as housing, employment or social welfare services or shorter-term needs such as a washroom, a phone or a computer with internet access. Participants do not expect future services to provide all these features, but rather that the MHSUH system will work within a collaborative structure that allows someone who is connected to those services to navigate toward other programs and services that are indispensable to meeting their holistic needs.

Participants in the second phase of consultation called this vision the "every door is the right door" approach. Service providers, policymakers and other experts agreed that person-centred care should be a priority and that the creation of collaborative networks among various systems of care is a first step in moving toward the ideal future state described by first phase participants. Second phase participants added that family involvement in care can be important, especially for racialized and newcomer communities, and that privacy legislation around family involvement in care should be reviewed to allow for cases where it can support positive wellness outcomes.

Continuity of Care

Participants in both phases agreed that the future state of MHSUH care is one that provides a continuity of care that follows someone throughout the various stages of their lives and evolves services to meet evolving strengths and needs throughout this life journey.

Participants in every engagement session talked about how the future state will include a navigator service, an easily accessible "one stop shop" that serves as a gateway to whatever services might be required and that accompanies a person along their journey from one service to another. Participants also talked about the idea of creating an office of rights advisors, a dedicated team of people responsible for helping a person manage their case and informing them about the options available to them. These advisors can also serve as a conduit between a person seeking care and their families or loved ones, advising someone on what rights their families may have, helping people navigate options alongside their families and sharing information among the person, their families and service providers, when appropriate.

Participants talked about how the future state would have two care components: immediate crisis response services and longer-term support services.

Immediate response services would be available to respond to urgent calls surrounding MHSUH crises and would include teams of healthcare professionals trained in addressing these types of situations, such as de-escalation training or overdose prevention training. These services would be available on-call, 24/7 across Canada, like the 911response but without the need of a police response. While participants recognized the recent roll-out of the national 998 hotline, they said there is a need for mobile response units that can respond to calls in person.

Longer-term support services can take a variety of different forms. In the future state, people would have access to various options they can consider and access, alongside their rights advisor, to tailor a wellness program that meets their needs and helps them achieve their objectives. While different approaches can be offered, they ideally should not compete against one another. Rather, the system should be designed so all services are working in one direction: supporting someone in achieving their definition of wellness. Participants said there is a need for services to be calibrated to varying intensities, from residential programs to drop-in centres, and to varying lengths, from 30 days to a few years, with programs that do not require someone to formally graduate or stop attending.

Participants talked about the idea of “owning the block” in providing continuous care, where several programs supporting people at different points in their wellness journeys are co-located in a single area. While this model is being explored in several communities across the country and is one that has had success in supporting people in navigating sometimes overlapping services, some participants cautioned the co-location aspect can expose people to additional risks or harms they would not have otherwise encountered. Participants explained that there is a particular risk when co-locating programs for people who have stopped or are trying to stop using substances alongside programs for people who are continuing to use substances as part of their journeys.

"What if we owned the block or had a neighbourhood hub for treatment with different facilities that meet different needs?"

In the future state, there would be better systems in place to record, store and share information about people's journeys, including with that person and among the services they are accessing. Participants raised the idea of a portal that is accessible to service providers, healthcare providers, people seeking care, their rights advisors and, if the person consents, their families or loved ones. This portal would allow information to be easily shared between providers so it does not have to be given more than once and would allow the person seeking care or their loved ones to include additional details that might be relevant to their care. At the same time, participants cautioned there are serious risks to the creation of this kind of tool, including data protection risks and risks associated with how information on people is currently communicated and portrayed by medical professionals.

Once people have had the opportunity to access and receive care, the future state should make space for support and ongoing care after someone has left a program or service. This component of care might include aftercare, follow-ups, the availability of drop-in programs or connection to other community-based services to promote ongoing wellness. Participants envision this piece to be part of the rights advisor role designed to support people in navigating services, but it will also be the responsibility of other service systems such as housing, healthcare, or child welfare to ensure that people remain tapped into a continuity of services to meet their strengths and needs.

Reducing Barriers

Participants in the first and second phase envision that the future state of MHSUH care is one that has created structures and measures to proactively reduce the barriers experienced by people seeking care.

The first barrier that should be addressed is the gap in information about what services are available, the steps required to access them and what should be expected once someone does access them. It should be easy to identify available services and specify the type of services someone is looking for, including services that are reflective of a person’s identities and experiences.

Another barrier is the lack of coordination among services, which can lead services to drop someone either because they do not have the capacity to provide adequate support or because the person has lapsed on a particular requirement of the program. While it is not expected that every program provide services to every person, participants do expect that the future has enough networks in place so someone is able to access services regardless of the circumstances of their situation.

Third, participants identified the prohibitive cost associated with several services, especially those that are privately offered, as a barrier to accessing care. The future state would be able to provide these types of private services through a public healthcare system, making quality MHSUH care available and accessible to everyone. The future state would be one in which high-quality care is adequately funded and staff are adequately supported to prevent additional systematic barriers from interfering with the capacity of service providers to deliver strong services. In this world, MHSUH care would be available and accessible at reduced or no cost to everyone in Canada.

The future state would create more opportunities for service providers to work in and build relationships with remote, rural and northern communities, including exploring ways to increase digital access to services for times when providers are not able to operate in person. One example is the construction of sound-proofed rooms in community centres or town halls that would provide access to video connection services, allowing community members to connect with providers in a space that feels safe, comfortable and close by.

Participants said there are tremendous opportunities to explore the role of digital health approaches in the future state but that more conversations are needed around the implications of these technological integrations. Opportunities for leveraging technologies include being able to access virtual care or developing records that are accessible and transferable among service providers. While these opportunities abound, participants also flagged previously mentioned risks surrounding recording and sharing sensitive health information among providers.

Systematic Integration

First and second phase participants talked at length about how the future state of MHSUH care would be one where the various nodes of systems of care are integrated and work collaboratively to provide support to people in ways that meet their strengths and needs. While participants expect there to be an increased level of integration among MHSUH services, the future state goes beyond this and includes other care systems that impact people’s lives, such as housing, employment and child welfare.

In every engagement session, participants discussed the intersections among mental health, substance use health and other parts of people's lives such as their experiences as children (especially if they were involved in the child welfare system) and their ability to access social welfare services, housing services and even employment. There are many harmful and traumatic experiences in a person's life that can be directly tied to them interacting with other systems, and the unfortunate reality is that these systems are not equipped to help guide someone toward wellness. In the future state, various systems would be able to work together and would consider MHSUH lenses when supporting someone in accessing services.

One example emerges when considering how access to safe, affordable and appropriate housing is instrumental to positive mental health outcomes. In the current state, there is a failure to recognize the devastating impacts the housing crisis is having on the mental health and wellness of people in Canada. Alongside an increased availability of affordable and appropriate housing across the country, the future state would include multiple points of connection between housing and MHSUH care for those who need it. These connections can include resources around supporting people in maintaining their existing housing while they attend MHSUH programs locally or away from their homes. Similar connections and integrated resources should be identified and offered to people living with MHSUH challenges at the intersections of the child welfare system, especially for youth who have "aged out of care," people with experiences of criminalization or incarceration and people with low incomes.

"I'm interested in your wellness. I'm not interested in your use of substances."

Participants stressed that the improvement of MHSUH services cannot happen within the siloes of provincial or territorial jurisdictions. They discussed how difficult it can be to coordinate services among jurisdictions, either as someone seeking care or someone coordinating services for a loved one in another province or outside of a particular jurisdiction. In the future state, MHSUH standards would make accessing services a similar and positive experience in each province and territory, making it easier for people to locate support and receive care from services regardless of where they are in the country.

Participants also believe the MHSUH service network should reduce the involvement of law enforcement in response to crises and in the delivery of services. Participants across the country said the police are not an appropriate response to most MHSUH concerns, despite police carrying much of the existing burden to respond at times of crisis.

Participants encouraged reallocating police funding toward other immediate response services, involving healthcare practitioners like nurses in front-line response teams and increasing the training that police officers receive in order to provide appropriate, compassionate MHSUH responses. In the future state, police do not need to be relied upon to respond to MHSUH crises or, should they be involved, their response does not lead to death or harm and is implemented in a way that is kind, compassionate and trauma-informed.

<u>Measurable Standards</u>

First phase participants believe there is an important role for standards in the implementation of the future state of MHSUH care. They see standardization as a way to guarantee a high quality of care and the credibility of particular services, leading to overall better wellness outcomes for people. Standards were imagined by participants as benchmarks from which to measure progress toward the future state described previously. Standards are also a way to evaluate services, keep services accountable and, ultimately, shutter services that are deemed harmful.

“Policies and standards can anchor the work that you are doing.”

Second phase participants agreed that national standards have the potential to guarantee accountability in the system, ensuring each node of the system meets the requirements set out for it. They added it will be important to ensure that standards go beyond the existing scope of care and barriers to receiving care, as there are many people who are unable to access services in the current system.

How to Move from the Current to the Future State of Care

Participants were then asked to explore the steps or actions that must be taken for the MHSUH system to move from the current state of existing care to the desired future state participants imagined.

Urgent Actions

Across the country, participants in both phases of the consultation process highlighted that people are experiencing several crises simultaneously: a housing and affordability crisis, a toxic drug crisis and a growing need for MHSUH care. While national standards can play an important role in driving change forward, participants stressed that people die every day as a direct result of inaction surrounding these crises and there is not enough time for people to wait for MHSUH care to be standardized.

“I’m sick of losing people I love.”

Participants emphasized the need to implement programs and policies that prevent deaths and further harms. There are several crisis intervention and harm reduction approaches across the country that work and are keeping people alive long enough to access other services. As standards begin to strengthen the MHSUH system, there is a need to continue to value and, in some cases, fund these types of approaches that are on the front lines of reducing harms and saving lives. Participants, particularly in the second phase, were mindful that, while continued support for services that meet acute needs is indispensable, the same attention and resourcing must be invested in services supporting people at other points of MHSUH spectrums.

Participants stressed the importance of investing in on-the-ground services that meet people where they are, accept people as they come and connect people with various systems of care. These services are often the first point of contact for people and serve as a critical component of building out a strengthened MHSUH system. A concrete action is providing up-front investment for community-based organizations to continue offering services at the local level. This investment will benefit people in the long-term by laying the groundwork for integrated and collaborative social support systems.

Centralized Access

In most engagement sessions, first and second phase participants said one of the most impactful actions that could be taken is the creation of a centralized source of information and access for MHSUH services. This central hub would consolidate and maintain an accurate database of information about services, their availabilities and wait times, whether they offer specific culture- or identity-based services, and the procedures or referrals required to access them in a timely manner. An inventory like this would serve an informational purpose and offer a single point of entry to any number of services contained in the database.

“We absolutely need centralized access, but absolutely need decentralized service.”

Participants appreciated the concept that “any door is the right door,” meaning that regardless of how someone reaches out to services either directly, at hospitals, at school or at any other contact points in their community, they are directed toward the central hub and supported with further connections from there. This is where the navigator or rights advisor would serve as an advocate or case manager tasked with assisting in research, outreach and referrals to programs or services. This person or team could remain as a consistent source of support throughout a person’s wellness journey, especially in understanding the options or barriers that could affect the achievement of a person’s wellness goals.

The central hub could also be responsible for overseeing the records that are compiled and shared among service providers, people seeking care and their families or loved ones. Considering this function, participants reiterated the importance of safeguards and other information management systems to protect sensitive health information.

Flexible Services

Participants in the first phase listed several steps that must be taken before it is possible to provide more flexible and responsive care, many of which correspond to the vision shared by participants for the ideal MHSUH system in the future.

Services must be responsive to the varying strengths and needs of different communities based on their intersecting identities, including cultural communities, language minority communities, men and women with their own experiences, and people who experience solely a mental health challenge or a substance use health challenge. They must be responsive to complex and concurrent cases of mental health challenges and substance use health challenges, including complex traumas, poly-substance use health issues or combined mental health and substance use health challenges. This includes adapting services to meet the needs and issues that might emerge surrounding changes in the toxic drug supply and the impacts these changes have on people who use drugs.

Services must be adaptable to the geographic, social and economic realities of individuals and communities, including providing support around a person needing to access transportation and accommodation to arrive at a service, ensuring they can rely on employment and housing security while they are away and that the costs for them to access the service are reduced or removed. By reducing these barriers, all people will be able to have access to services and be more likely to benefit from receiving care from them.

Participants highlighted the need to invest in a variety of mobile, pop-up or immediate response programs to help connect more services with more people in communities. They talked about the opportunity to explore and invest in new technologies that can better support and equip service providers and organizations. One participant shared the idea of creating a wearable device for people in precarious situations, including those who are unhoused or who are using drugs that can notify emergency services in case of an overdose or other emergencies.

Participants believe there is a growing role for technologies in increasing timely and streamlined access to services across the country. They spoke about the importance of investing in specific strategies to address gaps and barriers in remote, rural and northern communities and encouraged more consultations in those regions to better understand the nuances of the challenges and opportunities that may not exist in other communities. While technological and consultative solutions could help, there remains a need to ensure access in remote, rural and northern regions to community-based services that focus on relationship-building in a safe and positive environment.

There is also a need to invest in specific strategies to increase access to services for certain equity-deserving communities, including people who are unhoused and people who are incarcerated. People with experiences of being unhoused or criminalized are more likely to interact with systems of care but less likely to be provided adequate care or any care at all. The recommendation for removing siloes, fostering integration and collaborating with shelter services, correction facilities and other service nodes to increase access are particularly important for these groups.

Funding Services

Across the country, first phase participants highlighted critical capacity gaps in our healthcare system which continue to be relied upon to carry much of the burden related to MHSUH needs. There is a drastic need to increase funding for MHSUH services, including detox programs, drop-in programs, in-hospital programs, longer-term care programs, harm reduction programs, emergency response and crisis intervention programs and other community-based programs in every region in Canada. Participants highlighted that investment would help to keep existing staff, train new staff and ensure that all staff are provided with adequate compensation and related supports. Participants, especially in the second phase, believe that staff who are cared for are better able to care for others, which will help to expand system capacity in a sustainable way. They also stressed the importance of investing in training and hiring more service and healthcare providers who are themselves people with living and lived expertise, as peer supporters and beyond that role, in order to better identify the strengths and needs that people bring when accessing services.

“I wish we had the funding to have a treatment centre run by those who have experienced the same.”

Participants discussed the role played by families, loved ones or other non-paid caregivers in supporting a person’s wellness journey. In many cases, their involvement takes the form of completing unpaid work, paying for transportation or accommodation to attend services, or helping someone navigate the system and advocate for their care. The contributions made by caregivers and loved ones should be recognized and valued, and they should be better supported by offering them connection, community, resources or their own supports. Investment is also needed in more middle-spectrum services, including for caregivers and loved ones, that allow people who need support or who want to explore their own experiences at a particular time to access relevant services.

Participants emphasized the critical importance of increasing investment in existing services and investing in new ones that target the majority of people who are not in acute need and could benefit from middle-spectrum care. This expansion in the scope of services might include increasing access to flexible or drop-in services, capacity-building programs such as awareness-raising or public education, and in-patient spots for MHSUH needs in hospitals or primary care settings. Participants added the importance of investing in people, working to ensure funding can flow directly to those in need, increasing their ability to navigate services independently.

Second phase participants added that, as gaps are identified, efforts should be made to leverage them as a means of finding new approaches to expediting access to care and providing services in a more effective way. They added that the increased funding required to invest in care could come from reallocating resources or be taken from existing excise taxes on substances including alcohol, tobacco and cannabis.

Education and Training

Nearly every engagement session across both phases raised the need to tackle stigma by fighting misinformation and promoting conversations and narratives around wellness. Education and training will play an important role in changing these conversations, and participants saw this as an obvious place to start making change. Participants also believe there is an important role for standards to play in establishing educational curricula, training programs and public awareness campaigns across the country, ensuring information is accurate and rooted in compassion for people with living and lived expertise.

Participants said that, given the concerning trend of service providers and medical practitioners relying on information that is considered outdated or dangerous, there is a need to invest in ongoing training and education on MHSUH care. This could involve the mandatory inclusion of content on MHSUH challenges in school curricula, as well as resources and support surrounding the options for MHSUH care that can be offered and the best ways of offering and implementing them in a manner that is compassionate and person-centred. Providers and practitioners should also be made aware of other services that meet core needs such as housing and employment which can similarly be offered and integrated into a person's wellness journey.

"Launch a campaign to educate service providers and the public about mental health and substance use health as a way to reduce stigma."

Beyond the care space, participants encouraged investment in education for the general public on MHSUH challenges and opportunities, including awareness and education campaigns aimed at better equipping people to talk about and normalize holding conversations on MHSUH care. While participants recognized that pervasive stigma and other barriers might prevent older people from openly discussing their perspectives and experiences, there is an opportunity to start having conversations in schools about mental wellness and people's relationships to substances and substance use health in a manner that is similar to how sexual education is already delivered.

Another idea highlighted in several sessions was the need to invest in de-escalation training and other educational programs focused on compassion for law enforcement and other emergency responders. To mitigate the harm and even death caused by current responses, some participants suggested the creation of experiential learning programs, built alongside people with living and lived expertise, that would help police, medical professionals and service providers experience life as a person who is unhoused. It was hoped their participation in this type of program would spark empathy, reflection on the stigmatization that people endure and reinforcement of the need for health and community-based responses to MHSUH crises.

Participants emphasized that any training and education programming or service provision should be designed and implemented alongside people with living and lived expertise to increase their success in being representative, reducing stigma and redistributing resources toward them and their expertise.

Living and Lived Expertise

Participants stressed the overarching goal of humanizing and bridging the perspectives and experiences of people with living and lived expertise. They believed that most people themselves have some degree of living and lived expertise but that the stigmatization of MHSUH challenges forces many to ignore or hide those parts of their identities. It is crucial to spotlight and provide platforms for the positive, negative and in between stories of people with living and lived expertise and their reflections and insights on what is most supportive for them in their journeys toward wellness.

Participants in the first and second phases repeated the need to have people with living and lived expertise drive program and service design and implementation and to have their representation at decision-making tables as a further step toward inclusion and equity. This representation would include inviting their collaboration in the establishment and evaluation of national standards on MHSUH care.

Policy Measures

Although somewhat beyond the scope of examining the role of standardization in improving the MHSUH system in Canada, participants in the first and second consultation phases also offered some views on policy issues that could contribute to a better system. They explained that it is important to create a policy environment in which differing approaches to service provision are equally weighted options for a person to choose from that will get them closer to their wellness goals.

Participants spotlighted policies related to consent, including consent to involve families or loved ones and consent to share information about a person seeking care to them or to service providers. Participants also discussed the question of involuntary care and whether there should be policies that could trigger the automatic admission of a person into care without their consent. Particularly in the second phase, participants argued there is a need to review existing policies, ensuring that the right safeguards are in place but making them more flexible depending on the situation. Participants suggested that, when it comes to family relationships, there needs to be a more nuanced approach to ethics and human rights questions that respects the autonomy of people but that also considers family involvement, within reason, in cases where people are unable to care for themselves.

Within the scope of the MHSUH system, participants shared that the introduction of new policies such as the decriminalization of substances and the provision of a safe supply of substances would go a long way in addressing systemic issues and the resulting barriers as the root causes of the harms and inequities experienced across the country. They suggested that, by relying on the existing evidence and experience base, policy makers could look to success stories in other jurisdictions or countries for inspiration surrounding the learnings and best practices that could be applied to decriminalization or safe supply.

Additionally, participants expressed a need to review policies outside the scope of MHSUH care, including policies related to supportive housing, subsidized housing and private service delivery partners. They explained that there are several housing programs that put people with MHSUH challenges in harmful or dangerous environments without recognizing the potential risks to them. These programs, including single occupancy housing programs in British Columbia, can be detrimental to people’s mental health and, in many cases, need to face the same scrutiny and standardization as other services in the MHSUH landscape. Another example lies in private service delivery partners such as pharmacies, some of which underserve community members while overcharging the provincial government for services that may not have been delivered. Participants recommended these services be similarly assessed and standardized.

Standardization Measures

Participants in the first and second consultation phases viewed national standards, if developed and implemented correctly, as a tool to establish and guarantee a high quality of care that could lead to positive wellness outcomes. First phase participants shared several recommendations for how to concretely leverage standards in a way that prioritizes wellness and person-centred care.

First phase participants said there should be a mechanism through which people seeking care and their caregivers can provide feedback on their experiences with services against standards in the system, creating a path toward accountability in cases where services do not operate as they should or cause harm to people. To support this recommendation, participants suggested assigning a care ombudsperson who would be responsible for taking complaints, completing investigations and holding services and governments accountable against standards.

Participants reiterated throughout the conversations that, while standards might play a role in strengthening the quality of services provided by health organizations, the true benefit will come from active and proactive oversight, tracking, reporting and evaluating against those standards by government. They suggested that healthcare funding be tied to standards regulating care, which could include adjusting funding to provinces, territories or service providers that do not meet certain levels of care according to those standards.

Second phase participants agreed that funding to governments and service providers should be tied to their ability to meet standards, but this allocation should not increase the administrative burden on providers and programs when it comes to planning, implementation, evaluation and reporting. Participants also said that there is an opportunity for standards to go beyond service provision and interact with public education, academic curriculum and professional training as a means of introducing standardization to adjacent systems.

Finally, and importantly, first and second phase participants saw the potential offered by standards but were weary that they might reinforce the types of ‘one-size-fits-all’ services that have led to the many harms described in the current state of care. They recommended that the principle of person-centred care be prioritized in standardization as a way to balance consistency in care with the flexibility, responsiveness and compassion required of effective services. One of the ways that standards can be made person-centred, as already discussed, is through their collaborative development and evaluation by people with living and lived expertise.

Conclusion

The national consultation process undertaken by Hill and Knowlton on behalf of the Standards Council of Canada and the National Mental Health and Substance Use Health Standardization Collaborative gathered learnings from more than 150 people across the country about their perspectives and experiences with accessing current mental health and substance use health services, their ideal vision for MHSUH services in the future and the key steps or actions that are needed to move the system forward in an equitable and compassionate way.

It is widely understood by consultation participants that there is an important role for standards and accreditation in strengthening the MHSUH system to have better outcomes for people living in Canada. These standards are seen by participants as something that can ensure a high level of service quality, create avenues for accountability around service delivery and help to evaluate the strength of the system and individual programs and services.

Participants believe that people with living and lived expertise should be at decision-making tables when creating and implementing these standards and evaluation mechanisms. Several participants expressed gratitude toward SCC for continuing conversations on the standardization of MHSUH care in communities and in spaces where they could share their perspectives and experiences openly and authentically.

Throughout the consultation process, participants shared a well-known reality: that the current state of MHSUH services is that of a broken system. There are fragmented services operating in siloes and with conflicting philosophies that are unable to coordinate with other services within or outside of the scope of the MHSUH system. There are structural barriers hardwired into the system that limit people's ability to access services, that create unnecessary harms and, in many cases, that cost people their lives. At the same time, there are positive examples of good work being done, but only because of the investment of time and effort that optimistic and inspiring staff are able to offer.

Participants dream of a future state of MHSUH care that takes action to keep people alive and makes care more accessible. They imagine person-centred and trauma-informed services that understand MHSUH care as a key component of overall human healthcare. They envision the barriers that will be eliminated, from cost to exclusion criteria, and the ways in which people can be supported throughout their wellness journeys in whatever forms work best for them.

They see “every door being the right door,” leading people toward a central hub with information on service options, care rights and a friendly guide to help them along the way. They also see the seamless integration of MHSUH services with other support systems such as housing, employment, child welfare and social assistance programs, providing a coordinated network of support that can surround a person and lift them up in every aspect that they need.

Participants explored the steps and actions that are needed to move MHSUH care from its current state to the ideal future state, including measures to keep people alive and reduce harm to people now. They talked about policy measures, both new and renewed, for addressing the structural gaps that exist. They shared important first steps, such as the centralized hub, increased funding and resourcing, and investment in different types of services to meet diverse strengths and needs, all in an attempt to increase system capacity and ensure system sustainability. An important piece of the puzzle also includes raising awareness, offering training and education and, ultimately, helping people become more comfortable talking about their own perspectives and experiences, especially at an early age.

Across the country, participants shared that the solutions exist and that the people working on the ground every day, including the people navigating care for themselves, know what needs to be done and where best to invest to strengthen the MHSUH system in Canada. It is not a question of research to them but a question of implementation that the government must now take on with support and direction from those who know the system the best.

Participants believe that better health outcomes for people in Canada, following individual and collective journeys toward self-defined wellness, is not only possible. It is just around the corner. All that is required now is a roadmap and a willingness to get there.

NATIONAL MENTAL HEALTH AND SUBSTANCE USE HEALTH STANDARDIZATION COLLABORATIVE

CHALLENGING RACISM AND BUILDING EQUITY IN MHSUH SYSTEMS WITHIN A STANDARDIZATION CONTEXT

March 26, 2024

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1. EXECUTIVE SUMMARY

In 2019, SCC published a report on gender and standardization, which emphasized that standards are not neutral in their impact – they are shaped by those involved in their development and implementation. The report highlighted a concerning finding: standards do not offer the same level of protection to women as they do to men, partly due to the underrepresentation of women in standards development and a lack of gender expertise in the process. To address this disparity, SCC devised a Gender and Standardization Strategy aimed at increasing gender representation, integrating gender expertise into standardization, and conducting research to identify and rectify gender inequities. As a result, gender considerations have gained greater prominence within SCC, and national leadership is also helping bring those considerations to international standards development.

Building on the success of SCC's efforts in promoting gender-responsive standards, a similar approach could be expanded to address issues of equity and anti-racism, thereby fostering a more representative and equitable standardization system. Initially focusing on mental health and substance use health (MHSUH) standards, this approach could eventually encompass a broader examination of systemic racism throughout the entire system.

To facilitate this expansion, SCC engaged The Firelight Group (Firelight) to support the drafting of this chapter through a literature scan and undertaking several sessions/interviews with Black people, Indigenous people, and people of colour (BIPOC) largely drawn from the Collaborative membership aimed at drafting a report for the Roadmap that explores the unique challenges faced by racialized communities, particularly BIPOC, who encounter disproportionate barriers to accessing quality care due to racism and discrimination. By exploring the intersection of racism and MHSUH, the report aims to provide a comprehensive understanding of the complex social determinants influencing outcomes in these areas. It emphasizes the adoption of anti-racist approaches in healthcare delivery to ensure equitable access and support for all individuals, irrespective of their background or ethnicity.

Racism permeates various levels of MUSUH systems, from interpersonal biases to institutionalized discrimination. BIPOC individuals often face barriers to care, encounter culturally insensitive services, and are disproportionately affected by overcriminalization which shapes care pathways. These systemic failures exacerbate mental health and substance use challenges, leading to poorer health outcomes and perpetuating cycles of marginalization.

To effectively tackle racism within mental health and substance use health systems, a multifaceted approach is needed:

- *Legislative Reforms*: Prioritizing equitable access to care through legislative measures that recognize and address systemic barriers faced by BIPOC communities.

- *Culturally Humility and Anti-Racism Frameworks*: Adopting cultural humility and anti-racism frameworks for service provision that center the experiences and needs of diverse communities and engenders both program and system transformation.

- *Community-Specific Programs*: Developing tailored programs rooted in strengths-based approaches, acknowledging, and leveraging the resilience and assets within BIPOC communities.

- *Monitoring and Evaluation*: Implementing robust mechanisms for monitoring and evaluating progress, developed in collaboration with communities, to identify areas for improvement and hold institutions accountable.

Each of these key areas must be undertaken in partnership with racialized communities themselves on order to ensure policy and program approaches meet their specific needs and aspirations and respects the self-determination and authority of diverse peoples to speak for themselves.

By centering anti-racism and equity in the development of standards, the Collaborative aims to dismantle systemic racism within mental health and substance use health systems and pave the way towards greater equity and inclusivity. This involves partnering with BIPOC individuals, communities, and organizations, identifying effective practices for preventing and responding to racism, and ensuring that standards actively contribute to dismantling systemic inequities. Continued efforts to amplify the voices of BIPOC communities, advocate for legislative reforms, and foster partnerships rooted in equity and anti-racism are integral for creating a healthcare system that truly serves and uplifts every individual, regardless of race or ethnicity.

2. METHODS

Developing this chapter included undertaking a literature scan and a limited set of engagements drawn from BIPOC members of the MHSUH Standardization Collaborative.

2.1 LITERATURE SCAN

The literature scan involved reviewing relevant existing grey and academic literature including research articles, reports, policy documents, and event reports, on several topics including the impacts of racism on BIPOC mental health, racism faced by BIPOC folks within MHSUH, and recommendations to address racism and build equity within MHSUH systems, including the development of anti-racism and equity standards.

2.2 ENGAGEMENTS

Firelight completed four semi-structured focus groups/interviews with a total of seven key informants between March 8-26, 2024. The purpose of these engagements was to:

- Gather insights regarding what anti-racism practices or approaches can be learned from the MHSUH Collaborative members to promote equity and inclusivity within the standardization system, particularly within MHSUH services.
- Better understand the experiences of BIPOC folks accessing MHSUH services in Canada, including strengths, barriers, and challenges within the current service landscape; and,
- Identify anti-racist principles in the journey towards MHSUH standards and ensure that the standards developed contribute to dismantling systemic racism and reinforcement of equity thereby building a bridge to a more inclusive and just healthcare system.

Participants were encouraged to share in whichever way made them comfortable, whether it be storytelling or adding comments to the chat box function. Participants were encouraged to prioritize their own mental wellness, should any content provoke discomfort.

2.3 LIMITATIONS

The information contained within this report is based on feedback provided during a limited number of initial engagements, primarily comprised of BIPOC members of the MHSUH Standardization Collaborative, and a literature scan. While this chapter is an important look at considerations for anti-racism and equity standards with MHSUH, it should be understood as an early step in a longer journey that will involve deep engagement and co-development with BIPOC people and groups towards anti-racism and equity standards. In fact, the importance of this co-development was a nearly universal theme amongst our engagement participants.

3. INTRODUCTION

Racism is a pervasive issue that is deeply entrenched in various aspects of society, including in mental health and substance use health (MHSUH) systems, at the epistemic, systemic, and interpersonal levels. In the context of MHSUH, racism can manifest in numerous ways, impacting the access, quality, and outcomes of care for racialized communities including Black, Indigenous, and People of Colour (BIPOC), as well as immigrant and refugee populations. Addressing racism in these systems is not only a matter of social justice but also essential for improving health outcomes and achieving health equity.

This chapter explores the intersection of racism and MHSUH, highlighting the challenges faced by racialized communities and identifying strategies for advancing anti-racism and achieving equity in these critical areas, including a focus on standards. By examining current research, policy documents, and practices, this document aims to provide insights and recommendations for consideration as dialogue around MHSUH standards continues.

4. THE MANY FACES OF RACISM

The roots of racism run deep within society and within MHSUH systems, emerging at interpersonal, institutional, systemic, and epistemic levels. These forms of racism are interconnected and reinforce each other, leading to complex and entrenched patterns of discrimination and inequality. Unearthing these roots is the first step in generating a comprehensive response that challenges racism at all levels.

One of the most recognizable forms of racism is **interpersonal racism**, which occurs between individuals. In the context of this work, it can be observed in interactions between a healthcare practitioner and a racialized person and may involve acts of physical or emotional violence or discrimination. Interpersonal racism can be overt or more subtle, manifesting in small actions or inactions. Many forms of racism are rooted in stereotypes, which are distorted perceptions of social groups that fail to accurately represent their diversity. These stereotypes can negatively affect relationships between individuals and groups, leading to harmful assumptions about the traits or behaviours of entire racialized groups (Walker, 2008, as cited in Reading, 2013).

Systemic racism refers to the specific ways in which racism

> *is embedded in the policies and practices of institutions and organizations. Systemic racism operates directly or indirectly to sustain the power structures and advantages enjoyed by the dominant groups. It results in the unequal distribution of economic, social, and political resources and rewards among different "racial" groups* (Centre for Addictions and Mental Health, 2021, p. 24).

Within MHSUH, this can manifest through inequitable access to resources, programs, and services, policies and practices that explicitly or implicitly discriminate against racialized groups, the lack of diversity within the workforce including leadership positions, racial profiling, and disparate outcomes, and underrepresentation in research, among others.

A recent report from the First Peoples Wellness Circle (FPWC) and the Thunderbird Partnership Foundation (TPF) cite **epistemic racism** within MHSUH as a persistent barrier to achieving equity in programs/services and outcomes for First Nations, Inuit, and Métis peoples in Canada (2023).[1] The report defines epistemic racism as, "a type of racism that devalues certain forms of knowledge and certain holders of knowledge" (FPWC & TPF, 2023, p. 9). Similarly, several studies have cited epistemic racism, including notably the systems built from and responsive to Eurocentrism, as negatively impacting the health and wellbeing of the broader BIPOC community (Mfoafo-M'Carthy, 2014; Fante-Coleman & Jackson-Best, 2020).

Another important term that requires defining is intergenerational trauma, which refers to "the transmission of trauma across generations" (Ereyi-Osas, Song, Kalim, & Kekulawala, 2020). In *First People, Second Class Treatment,* authors Allan and Smylie describe intergenerational trauma within Indigenous communities as, "the rupture of identity, family and community perpetrated through [colonialism]…[which] has had lasting and intergenerational impacts, substantially interfering with or completely impeding the transmission of values, beliefs and practices, including parenting practices" (Allan & Smylie, 2015). These intergenerational impacts are felt in many racialized communities such as Black Canadians where "everyday experiences of racial trauma may be coupled with historical trauma related to Canada's past colonial history, with their involvement in the exploitation of African slaves if descendants from slavery, or histories related to experiences as refugees" (Ereyi-Osas, Song, Kalim, & Kekulawala, 2020).

4.1 INTERSECTIONS OF OPPRESSION

In general, stigma surrounding MHSUH remains a significant barrier for many individuals seeking support and treatment. This stigma often stems from misconceptions, fear, and lack of understanding, leading to discrimination and social exclusion. It not only impacts individuals' self-esteem and mental well-being but also hinders their willingness to seek help. This is before even getting into various demographic factors, such as race and ethnicity, which can further compound stigma.

Racialized people often face discrimination based on multiple, interconnected systems of power and privilege including race, gender, sexuality, religion, age, ability, and socio-economic status, among others (Skosireva et al., 2014; Anucha, Srikanthan, Siad-Togane, & Galabuzi, 2017). One prominent example is the crisis of missing and murdered Indigenous women and girls (MMIWG) which demonstrates the tragic outcome of systems of oppression creating a social hierarchy where Indigenous women and girls, as well as 2SLGBTQQIA+ people, are made vulnerable to "individual, institutional, and systemic violence" (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). Another example is the overlapping systems of

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[1] This report was developed by The Firelight Group on behalf of FPWC and TPF.

oppression around age, race, gender, and sometimes religion that has given rise to increased surveillance and criminalization of young Black men (Anucha, Srikanthan, Siad-Togane, & Galabuzi, 2017; Fante-Coleman, Booker, Craigg, Plumber, & Jackson-Best, 2022). Understanding these intersections is vital to unearthing and challenging the ways in which people from various locations experience racism including within MHSUH systems.

5. IMPACT OF RACISM ON INDIVIDUALS AND COMMUNITIES

Racism, in all its manifestations, has a profound impact on the physical, mental, spiritual, and emotional health and well-being of racialized people and communities even before considering how racism within MHSUH systems contributes to poor outcomes (Black Health Alliance, 2015; Fung & Guzder, 2021; Williams, Khanna Roy, MacIntyre, & Faber, 2022; Dayo, n.d; Rodrigues et al., 2019; Kogan, Noorishad, Ndengeyingoma, Guerrier, & Cénat, 2022; Lee, Kellett, Seghal, & Van den Berg, 2017). Discrimination and prejudice can lead to chronic stress, anxiety, depression, and trauma, contributing to the development of mental health disorders. Williams, Khanna Roy, MacIntyre, and Faber (2022) offer the diagram below to demonstrate how individual and collective racism, both historic and contemporary, generates poor mental health outcomes ranging from anxiety and depression to post-traumatic stress disorder (PTSD).

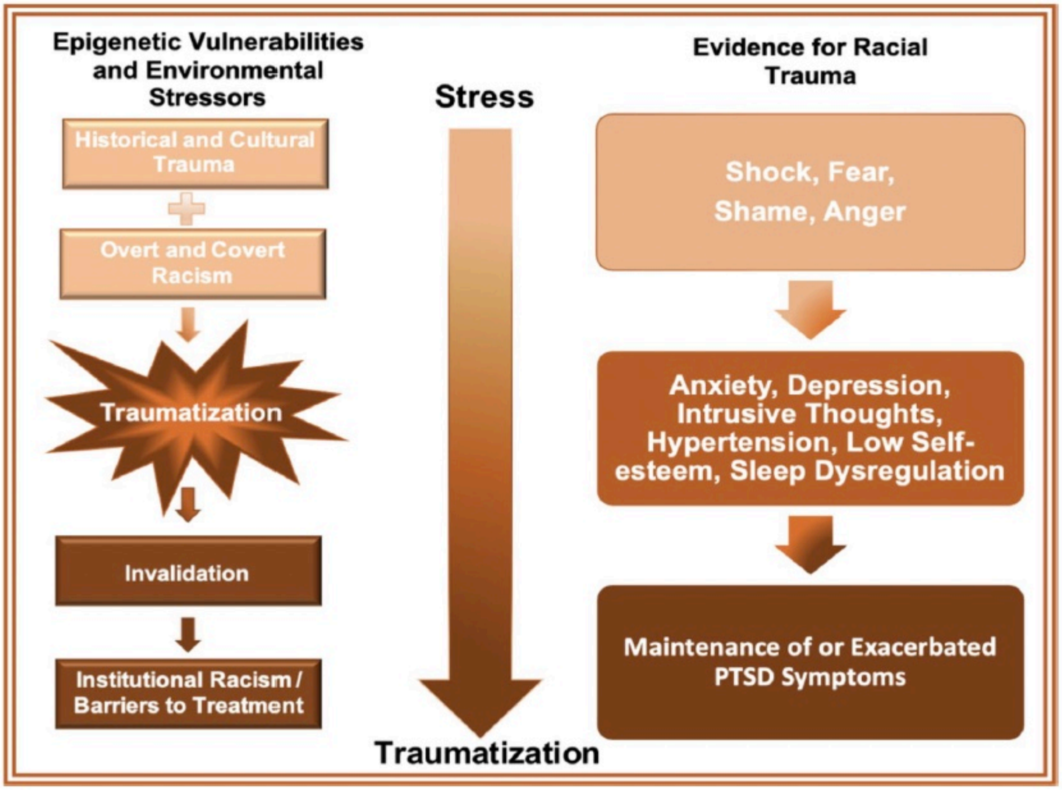

Figure 1 - Cumulative effects of racial stress and trauma, from Williams, Khanna Roy, MacIntyre, and Faber, 2022, p. 19, figure 2.

Chronic stress caused by racism also impacts physical health including higher rates of conditions like hypertension, diabetes, and cardiovascular disease among racialized populations. In many cases, this is compounded by the socio-economic barriers that both emerged from and reinforce racism such as poverty and lack of adequate housing.

In addition, given the connection between racism and chronic stress, it should be no surprise that some racialized people who live with interpersonal, systemic, and epistemic racism may use substances as a means of coping. For example, Cheyenne Johnson and Dr. Nel Wieman of BC’s First Nations Health Authority (FNHA) note:

> *The intergenerational trauma carried by the many families who survived the residential school system and other racist federal government and provincial governments' policies, including the Sixties' Scoop, are for many a deeply rooted cause of harmful substance use, addiction, and mental illness. For First Nations people who have a history of trauma, the odds of using substances like opioids in a harmful way are 2.9 times greater than those who do not have a history of trauma* (2021).

This points to the fact that the oppression can look and feel differently in different communities. For example, the reality of settler colonialism in Canada, where Indigenous peoples were dislocated from their land, values, systems of governance, and worldviews and where non-Indigenous people continue to benefit from that dislocation is a specific kind of pain and trauma. The source of racial trauma is different again for refugees, Black youth, etc. This is vital to understand both in terms of understanding the connection between racism and MHSUH outcomes, as well as constructing meaningful responses to racism within MHSUH.

6. MANIFESTATIONS OF RACISM WITHIN MHSUH

Not only does racism contribute to mental health and substance use challenges for racialized people, but it also can be found within the very same MHSUH systems that are supposed to offer care and healing to all people. From the individual to the epistemic, the following section highlights how racism can emerge within the MHSUH context. Though we provide a high-level look at the ways in which racism emerges within MHSUH generally, it is also important to recognize that racism can look different to various racialized groups. These differences are vital to recognize and account for when creating culturally safe and responsive MHSUH programs and services.

6.1 BARRIERS TO CARE

Persistent inattention to the mental health and substance use health needs of racialized peoples in Canada is a reflection and outcome of deeply rooted racism (FPWC & TPF, 2023). This includes the lack of services for people living in certain geographies, and the lack of consideration for the sorts of social and economic obstacles faced by many racialized people seeking care (Mahabir, et al., 2021; Black Health Alliance, 2015; Fante-Coleman & Jackson-Best, 2020). Other barriers include long waits for existing programs, the high cost of uninsured services, high administrative burden and restrictive policies for people seeking care, and siloed services (McKenzie, Agic, Tuck, & Antwi, 2016; Fante-Coleman, Booker, Craigg, Plumber, & Jackson-Best, 2022). Further, language barriers remain a persistant barrier, particularly for immigrant and refugee populations in accessing adequate MHSUH (McKenzie, Agic, Tuck, & Antwi, 2016; Godkhindi, Nussey, & O'Shea, 2022; Mahabir, et al., 2021; Goodfellow & Kouri, 2022). Finally, stigma, self-stigma, fear, and lack of understanding around mental wellness or available services may prevent racialized people from accessing care (Fante-Colement & Best, 2020).

The lack of culturally relevant and safe programs and services is a persistent barrier to care for BIPOC peoples in Canada, rooted in the racist, sometimes unconscious, belief of the supremacy of Eurocentric ways of knowing, being, and doing (FPWC & TPF, 2023; Godkhindi, Nussey, & O'Shea, 2022; Mahabir, et al., 2021; Levy, Ansara, & Stover, 2013). Different communities require different programs and services to meet their cultural understandings and material needs. For example, a 2019 study found that many immigrant and refugee "clients believed mental illness to be a Western concept used by healthcare professionals. Clients preferred going to family, friends, or spiritual leaders to address their concerns or receive support for life stressors and were uncomfortable talking with healthcare professionals" (Salami, Salma, & Hegadoren, 2019).

Similarly, many Indigenous peoples prefer care centred on Indigenous knowledge including "traditional healing practices, land-based practices, cultural reconnection, story-telling and oral traditions, family and community-centred care, holistic approaches…and healing-centred care" (FPWC & TPF, 2023). There is also a lack of MHSUH programs that take on the social determinants of health (SDOH) that impact the mental health of BIPOC peoples in Canada. (Salami, Salma, & Hegadoren, 2019; FPWC & TPF, 2023; Fante-Coleman, Booker, Craigg, Plumber, & Jackson-Best, 2022). These SDOH include poverty, food and housing security, social support networks, culture, education and literacy, and social environments, among others.

Just as with mental healthcare, substance use health is also deeply entrenched in Eurocentrism. This is problematic in that "racialized individuals continue to experience substance use differently from white individuals" largely as a result of the long history of xenophobic drug policy in Canada (Godkhindi, Nussey, & O'Shea, 2022). For example, several documented barriers for racialized folks within harm reduction include the shame that is more pronounced in some communities and the lack of diversity within both service providers and service users leading to distrust and disconnection (Godkhindi, Nussey, & O'Shea, 2022). Within Indigenous populations, a significant amount of substance use care is built on Christian religious doctrine (Lavalley, et al., 2020). This is particularly problematic given the role of Christianity in the historic and ongoing colonial traumas faced by Indigenous peoples in Canada. Additionally, treatment programs which are heavily rule- and coersion-based may bring up colonial trauma for Indigenous people, some of whom may have been survivors of residential schools where authority leveled against them was often violent (Lavalley et al., 2020).

In addition, individuals with intersecting identities struggle to access care that is safe enough to bring forward their full selves, including 2SLGBTQQIA+ people of colour. This complexity is shown in a 2022 report from the Black Health Alliance describing the bind that some Black 2SLGBTQQIA+ youth face:

> *Having to choose between a mainstream, anti-Black service organization that would celebrate and understand their sexual orientation and gender identities, and a Black-focused organization that could be homophobic and transphobic. Black 2SLGBTQ+ youth felt that mainstream services often centred whiteness, but at the same time, they couldn't bring their whole selves to Black-focused organizations*. (Fante-Coleman, Booker, Craigg, Plumber, & Jackson-Best, 2022, p. 35)

As described above there is a general lack of community and culturally-specific programming for BIPOC peoples in Canada, including in prevention programming such as public education, community-based wellness programs, and early intervention. In addition, a general lack of trust towards western service providers, fuelled by racism and inappropriateness of care, stigma, and fear, prevents people from racialized communities from seeking out care proactively (Cénat et al., 2023). In the case of Black people in Canada, when these factors combine with overcriminalization and racial profiling, the result is often that Black people are more likely to receive care later than white people, and are more likely to receive coercive care (brought in by police, ambulance or court order) (Fante-Coleman & Jackson-Best, 2020; Black Health Alliance, 2015; Cénat et al., 2023). In addition to different pathways to care, stereotypes may result in misdiagnosis such as a psychosis diagnoses rather than mood or post-traumatic disorders (Kirmayer & Jarvis, 2019).

When it comes to the realities of MHSUH for immigrants and newcomers to Canada, the research is notably scant (Ng & Zhang, 2021; Dayal, 2024). This gap in data risks missing the critical and unique barriers newcomers face in accessing MHSUH care, including differences within newcomer communities for example 2SLGBTQQIA+ folks and refugees. In addition, this lack of data risks missing the strengths of these groups that can be built upon in generating responsive, relevant, strengths based MHSUH programming (Dayal, 2024).

7. INSIGHTS ON STANDARDS CONTENT

The following section identifies best practices and strategies emerging from the literature scan and our engagements which provide insights into key content for anti-racism and equity standards themselves. While some key best practices and recommendations are outside the scope of the SCC's MHSUH Roadmap project, and some do not explicitly involve to the development of MHSUH standards, the objectives and principles that underly these promising practices are important starting points for considering how anti-racism and equity standards may look, as well as considerations for implementation and accountability.

7.1 LEGISLATION

A persistent challenge in delivering comprehensive MHSUH care generally, and anti-racist and culturally-relevant care specifically, is the treatment of MHSUH as outside of Canada's legislative public healthcare framework. By excluding MHSUH from legislation such as the Canada Health Act, MHSUH is treated as secondary to physical health, with profound consequences for individuals, communities, and systems as a whole, such as growing inequities between those who can afford supports and those who cannot; delayed treatments leading to increased long-term costs for systems; stigma and discrimination based on exclusion and social isolation; and ultimately, poor health outcomes. As such, several studies and reports have recommended either expansion of the Canada Health Act to include mental health, or the development of parity legislation for mental health (Fante-Coleman & Jackson-Best, 2020).; Canadian Mental Health Association, 2018). Through engagements we also heard about the potential of embedding anti-racism and equity standards within legislation as a mechanism of accountability and to sustain momentum over time.

7.2 CULTURAL HUMILITY, SAFETY, AND ANTI-RACISM

Several reports have indicated a general dissatisfaction amongst racialized people in Canada with the progress of the many health organizations who have committed to creating care free from racism (Fante-Coleman, Booker, Craigg, Plumber, & Jackson-Best, 2022; FPWC & TPF, 2023). Indigenous participants in one study described current efforts focused primarily on cultural competence as generally, "not engaging, ineffective, and fundamentally incapable of addressing the power imbalances within systems and society that are at the root of inequality and racism" (FPWC & TPF, 2023). Cultural competence is largely individualized approach where practitioners come to understand certain aspects of their clients' cultures. This risks entrenching stereotypes by viewing cultures as a static set of practices and features rather than complex way of knowing, doing, and being in the world (Kirmayer & Jarvis, 2019).

Given these critiques, cultural humility has emerged and is based on the recognition of the limits of practitioners to know and understand cultures other than their own. Further, cultural safety builds on this understanding by emphasizing the need for providers to reflect on their own biases and assumptions to provide care that is culturally appropriate and responsive and “works to redistribute power and control over healthcare delivery in ways that create a safe space for clinical work” (Kirmayer & Jarvis, 2019).

A complementary framework to cultural humility is an anti-racism framework which actively confronts and seeks to address the interpersonal, systemic, and epistemic racism that is embedded within health systems and society more broadly. Further, Mahabir, et al. argue that:

> *Anti-racism policies would explicitly identify structured unequal power relation systems of oppression and domination in order to explain the complex processes that generate racism, the continuation of racism, and its impact. An anti-racist framework that focuses on power and equity is needed to confront the myth of neutrality by understanding and connecting racism to the policy realm and social institutions in order to explain how racism is reproduced and its impact for racialized groups. This theoretically informed approach is also needed to explicitly name racism as a form of oppression and to hold institutions accountable* (2021, p. 11).

FPWC & TPF (2023) note that anti-racism frameworks are not just about deconstruction, though this is a key element. Alongside a deconstruction of the intersecting systems of oppression facing racialized people must be a focus on supporting the emergence of strengths-based perspectives of healing and wellness drawn from the many diverse cultural communities in Canada. One interview participant shared an example of this sort of strength-based cultural safety training in action, available to both staff and clients within a MHSUH setting. Both staff and clients were provided opportunities for cultural sharing through various means including healing modalities, music, and sharing of food. These opportunities seek to provide an approachable way in to talk about cultural values and thus increasing safety.

Importantly, we repeatedly heard that organizational and system leadership must be deeply committed to anti-racism and cultural safety in order to transform systems and organizational culture. While each and every person working within systems is responsible for being anti-racist and culturally safe, leaders hold an outsized responsibility to drive for innovation and improvement in this area.

7.3 TRAUMA AND VIOLENCE INFORMED CARE

The move to trauma-informed MHSUH care has become increasingly popular because it recognizes the profound impact of trauma on individuals and communities. It emphasizes understanding the cultural, social, and systemic factors that contribute to trauma among racialized populations and seeks to provide care that is sensitive to these factors (Browne, et al., 2016; Ereyi-Osas, Song, Kalim, & Kekulawala, 2020; Lavalley, et al., 2020). This approach involves creating a safe and empowering environment for individuals to share their experiences, acknowledging the impact of trauma on mental health and substance use health, and integrating trauma-informed practices into treatment and support services. However, the centering of trauma has also faced critique. Browne, et al. note:

> *The term trauma can be problematic in part because it signifies both traumatic events (often presumed to have occurred only in the past) and the responses to such events (often presumed to be only psychological). Indigenous and non-Indigenous scholars critique this 'trauma trend' because it both obscures the impact of ongoing structural violence and is often used to pathologize Indigenous peoples. We share these concerns and endorse the call for using a decolonizing lens when discussing trauma in relation to Indigenous peoples. Integrating attention to violence when discussing trauma keeps the focus on violence (both historic and ongoing) and reduces the likelihood of locating the 'problem' only in relation to the psychological impacts for those who have experienced violence, rather than also on structural violence and the conditions that support it* (2016, p. 12).

They propose centering the ongoing violence of systemic inequities alongside trauma – through trauma and violence informed care (TVIC) – in order to provide care that is based on the individual and community needs, and moves beyond individual pathology to take seriously the historic and ongoing traumatic impacts of violence faced by racialized peoples (Browne, et al., 2016).

7.4 REPRESENTATION, RECRUITMENT, AND RETENTION

Though it is certainly important to train all people working within MHSUH in cultural humility and anti-racism, it remains a key priority to ensure meaningful representation of racialized peoples in Canada within MHSUH systems through specific recruitment and retention efforts. This has the potential to enhance cultural competency, improve trust, and reduce barriers to care for racialized individuals (Pilarinos et al., 2023). This also includes ensuring meaningful inclusion of people with intersecting identifies such as members of the 2SLGBTQQIA+ community. One interview participant shared profound experiences of within their family and negative interactions with the police as an example of why BIPOC patients are reluctant to seek care from providers who do not look like them and do not share their experiences. The staff should reflect the ethnic, racial, and cultural make-up of the community that they serve. This contributes to both staff and patient safety.

Several reports have detailed specific recommendations to support the recruitment and retention of MHSUH professionals from BIPOC communities. Certainly, the approach may be different based on the community systems are seeking to draw from. However, recommended actions include:

- Recognizing credentials and establishing pathways to integrate diverse professionals into MHSUH systems (Kirmayer & Jarvis, 2019; CAHS, 2023);
- For training institutions to meaningfully engage with Indigenous peoples to co-develop curricula that centres Indigenous ways of knowing, being, and doing and better supports BIPOC learners (FPWC & TPF, 2023; CAHS, 2023);
- For MHSUH programs/services/systems to generate dedicated recruitment and retention strategies that may include cluster hiring, training and mentorship programs, and ensuring equitable pay and workloads (FPWC & TPF, 2023); and,
- Increase the diversity and representation of Indigenous and systemically disadvantaged groups within leadership positions through targets or "intentional inclusion" (Key informant interview, 2024).

7.5 COMMUNITY/CULTURE-SPECIFIC TOOLS, PROGRAMS, AND SERVICES

Community and culturally specific MHSUH tools, programs, and services are important because they address the unique needs and experiences of diverse communities. These programs recognize that MHSUH issues are influenced by political, historical, cultural, social, and environmental factors. These kinds of tailored programs confound the racist 'whiteness as default' foundation of a one-size-fits-all approach. By tailoring programs to specific communities, they can be more culturally relevant, accessible, and effective in addressing the root causes of mental health and substance use issues. Additionally, these programs can help reduce stigma, improve trust in healthcare providers, and support communities to take ownership of their mental health and well-being. Overall, community or culturally-specific programs play a crucial role in promoting equity, inclusivity, and better health outcomes for all individuals. The following section details some key features of this approach.

7.5.1 Community specificity and flexibility

Browne, et al. propose:

> *Expanding the concept of patient- and family-centred care, contextually tailored care includes services that are explicitly tailored to the local communities and populations served. This may include tailoring practices and/or organizational policies and clinical guidelines to address the needs of local population demographics, and social and community realities that often shift depending on local politics, epidemiological trends, and economic conditions (2016, p. 5).*

This deeply grassroots approach recognizes that there are important differences within and between communities that must be considered in programming planning and implementation. In some communities this may include addressing the SDOH through "nature- and food-related programs, gardening, and cooking classes" (Fante-Coleman, Booker, Craigg, Plumber, & Jackson-Best, 2022, p. 61). In other communities that may mean land-based healing, intergenerational connections (Elder and youth), and cultural practices (FPWC & TPF, 2023). For racialized 2SLGBTQQIA+ youth, for example, this means ensuring programs and services are affirming of all parts of their identities including their race, culture(s), sexuality, and gender expression (Fante-Coleman, Booker, Craigg, Plumber, & Jackson-Best, 2022).

Several sources also cited the importance of translation and cultural brokers based on identified community needs (Kirmayer & Jarvis, 2019; Maraj, Iyer, & Shah, 2018; Canadian Academy of Health Sciences, 2023). Clearly, language barriers have the potential to be very dangerous within MHSUH care environments and are likley to prevent those not proficient in English or French from seeking out or receiving high-quality care (Tulli, et al., 2020; Kirmayer & Jarvis, 2019). Beyond linguistic understanding, cultural brokers are staff working within systems that understand the cultural, historical, geographic contexts and nuances of the clients that they serve. While cultural brokers are identified in the literature as a best practice, it is noted that there are no "standards for training, assessment and quality assurance of culture brokers, nor are there established methods for funding this essential resource" (Kirmayer & Jarvis, 2019).

7.5.2 Strengths-based approaches

One insidious form of racism that impacts BIPOC people in Canada is the general societal view of many communities as inherently broken or weak. In engagement sessions towards the development of the Ontario Black Youth Action Plan, participants identified this deficits-based thinking as limiting the ability of MHSUH providers and society in general to see "the[ir] achievements, successes, contributions, hopes, and dreams" (Anucha, Srikanthan, Siad-Togane, & Galabuzi, 2017). Also emerging from a community engagement project, FPWC and the TPF identified deficits-based thinking and programming as fundamentally oppositional to the strengths-based culturally-rooted ways of knowing, being, and doing that have generated wellness for Indigenous peoples since time immemorial (FPWC & TPF, 2023). Instead, strengths-based programs and services could involve identifying and leveraging the strengths, resilience, and cultural assets of these communities to promote mental wellness and healing. One area where strengths-based approaches are valuable is within cultural-specific assessment tools. Engagement participants noted that current assessment tools have perpetuated harm, in this case to Indigenous peoples in Canada. Where the current tool identifies deficits within a client, a tool based on an Indigenous cultural understanding, for example, may see gifts.

7.5.3 Community partnerships, engagement, and self-determination

Building responsive MHSUH programs, services and systems "requires reaching beyond the healthcare system to engage stakeholders in community organizations, ethnocultural associations and religious institutions. This engagement can be animated by a shared respect for diversity and commitment to building a pluralistic civil society" (Kirmayer & Jarvis, 2019 p. 19). Community partnerships and engagement are fundamental to program success (Lavalley, et al., 2020; Anucha, Srikanthan, Siad-Togane, & Galabuzi, 2017; Pilarinos, et al., 2023; Centre for Addictions and Mental Health, 2021). Firstly, community input ensures the relevance of programs including elements related to cultural beliefs, practices, and values that should be considered in program design. Further, community partners can help identify barriers to accessing services both within and outside of the care system itself. Additionally, the visible and meaningful presence of community with program design and delivery works towards generating trust with those the program seeks to support. Finally, community involvement can help build local capacity and MHSUH literacy, and challenge stigma.

Beyond the simple fact that community involvement generates better programs and services, First Nations, Inuit, and Métis peoples in Canada hold specific legal and moral rights and responsiblities to self-determination over systems which impact them (FPWC & TPF, 2023). These rights and obligations to self-determination are rooted in treaties between First Nations and the Crown and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), among others.

While community partnerships and engagement is important, the current system often relies on BIPOC people and organizations doing this important work 'off the side of their desk,' or BIPOC people working within MHSUH systems to take on the emotional labour of 'fixing' the problems within the system (FPWC & TPF, 2023; Fante-Coleman, Booker, Craigg, Plumber, & Jackson-Best, 2022). Rather, what is required is dedicated and sustained capacity supports to undertake this transformational systems change, in partnership with local communities and experts.

7.5.4 A key caveat

One warning that was shared through our engagements around the idea of community and culture-specific programs was a fear that MHSUH programming for BIPOC folks will be treated as less than or apart from mainstream services, and that BIPOC people will not be provided choice in where they receive care. While there is broad support for these targeted programs, there is also support for ensuring all services are developed, implemented, and evaluated in terms of their ability to respond to the needs of diverse communities. One interviewee shared that, in most healthcare organizations a key question they ask themselves is 'who are they serving'. However, perhaps a more important question is, 'who are we not serving and why'. In a diverse urban community, for example, the demographic makeup of clients should reflect that diversity. Standards can help identify the systemic barriers that are preventing diverse communities from seeking or receiving care from all MHSUH programs and systems.

7.6 EXISTING STANDARDS

There are several existing standards that may be useful in providing some direction in the development of equity and anti-racism standards. In 2023, the World Health Organization (WHO) and the United Nations (UN) developed a guidance document supporting countries in ensuring a legislative framework that supports high-quality mental health programs and services that align with international human rights standards, specifically the Convention on the Rights of Persons with Disabilities (CRPD) (Word Health Organization & the United Nations, 2023). Embedding human rights within a legislative approach to mental wellness requires addressing "political, economic, social and cultural barriers while empowering individuals and groups, especially those that are most disadvantaged" (WHO & UN, 2023, p.16). Among the notable topics of particular relevance to this chapter include guidance on the development of legislation related to equity and non-discrimination, informed consent and eliminating coersive practices, access to high-quality mental health services, including person and rights based services within the community. Key learnings from this standard is the intergration of the SDOH.

In 2022, the First Nations Health Authority (FNHA) and the Health Standards Organization (HSO) released the British Columbia (BC) Cultural Safety and Humility Standard which provides guidance for organizations in challenging anti-Indigenous racism and generate systems where Indigenous peoples receive culturally safe, high-quality care (HSO, 2022). These standards seek to address anti-Indigenous racism at the structural, systemic, and interpersonal levels within health systems through dedicated changes in several areas including: generating accountability and transparency; relationship building; shared governance reflective of Indigenous self-determination; dedicating resources, policy development and training to prevent, respond to, and mitigate anti-Indigenous racism including within human resources; generating culturally safe services that center Indigenous knowledge and practices; and measuring impact through distinctions-based research and evaluation. What is particularly important within the Cultural Safety and Humility Standard is the throughline message that the implementation and measuring of these standards must be undertaken in relationship with First Nations, Inuit, and Métis communities were efforts are made to address the unequal relationship of power between health system and Indigenous peoples (HSO, 2022). It is also worth noting that the fact that these standards were developed in partnership with the FNHA, with input from Métis Nation British Columbia (MNBC).

8. AREAS FOR CONSIDERATION: DEVELOPMENT AND IMPLEMENTATION

In general, engagement participants support the notion of anti-racism and equity standards for MHSUH. Specifically, we heard optimism around standards as tools signaling an organization's commitment to anti-racism and equity, in providing guidance to organizations in meeting their social, moral, and ethical responsibilities, in spurring program innovation, and in advancing conversations around resourcing and investing in better serving BIPOC communities.

Whereas the previous section focused on insights related to the content of the standards themselves, this section describes important considerations related to development and implementation processes. These cross-cutting insights are listed below.

- **Build on momentum**: There are times when global events create the conditions for advancing anti-racism work. Many engagement participants noted the momentum generated for diversity, equity, and inclusion (EDI) efforts after the murder of George Floyd in 2020 at the hands of a white police officer in Minneapolis, Minnesota. While we heard that Mr. Floyd's death and the social movement that followed created significant momentum, we also heard that some felt this momentum was tempered by a simultaneous movement towards increasing division and push back against EDI. As such, several participants noted the need to capture momentum when it arises and focus on concrete measures that are more likely to be maintained in the face of potential societal and political pressures and shifts.

- **Clear, evidence-based, and efficient:** In addition to capturing momentum, standards will be effective if they are clear, based in evidence, and efficient. Most MHSUH programs, services, and systems would agree that achieving equity is an important goal. However, standards must also lay out a clear path forward in reaching achievable goals. This does not mean watering down the spirit and intent of the standards; rather, it requires being strategic and responsive to the realities of systems as they currently exist.

- **For us, by us:** Both the literature and our engagements revealed a common sentiment that the development, implementation, and evaluation of anti-racism and equity standards within MHSUH must be fully informed by those with lived and living expertise. As mentioned previously, this requires the commitment of long-term and adequate resourcing to support partner participation. In addition to creating standards that reflect the needs and priorities of diverse peoples, including BIPOC folks in the development, implementation and evaluation of standards will go some way in responding to the existing and understandable lack of trust between BIPOC communities and MHSUH systems.

- **Meaningful accountability:** Many health professions are well trained in standards of practice and understand the consequences of not living up to those standards with consequences levied by professional bodies. Several engagement participants shared that standards risk losing all credibility and moral authority if they are not accompanied by meaningful systems of accountability where programs, services, and systems can be met with consequences for not living up to their commitments to standards. Beyond just the providers and programs themselves, credibility will be lost within the BIPOC communities who committed time and energy to supporting the development of standards.

- **Highlighting success and building champions**: While an important characteristic of effective standards is accountability, it is also important to support MHSUH programs in taking on the challenge of meaningfully implementing standards. Several interview participants shared that launching national standards and getting buy-in from organizations across the country is an enormous task, which could be supported by demonstrating and promoting some early wins.

- **Implementation Tools:** Engagements revealed a shared perspective amongst many participants that for anti-racism and equity standards to be effective, there is a need to develop meaningful implementation and evaluation tools. One example shared of existing relevant and high-quality tools is EQUIP Healthcare, a research and implementation program to advance equity-oriented health care (EOHC) through the dimensions of trauma and violence informed care, cultural safety and anti-racism, and harm reduction and substance use health (EQUIP Healthcare, 2024). Tools available through EQUIP include guides, workbooks, budgetary information, among others, to support implementation of policies and system transformation aimed at generating equity. Another participant identified the Intercultural Development Inventory which supports individuals and systems grow in the area of intercultural competence (Intercultural Development Inventory, 2024).

Additionally, engagement participants emphasized the need for these tools to be developed in partnership with the relevant communities because it is these communities that hold the knowledge around what cultural safety and appropriateness means for them. On the evaluation side, measuring impact of culturally-relevant programs/services/systems must center the perspectives of the community that is being served based on what the community sees as important. We also heard that doing this work is labour intensive and challenging and requires meaningful capacity supports, as well as generating a process that respects the time and process of the partners.

- **Ethical research and evaluation**: The experiences of BIPOC communities and research demonstrates that research has and continues to do harm. The Black Health Equity Working Group powerfully describe what is at stake when it comes to data collection:

  > *Data is not just an academic tool or abstract entity. It’s our information. Locally and globally, Black people have been quantified, analyzed, utilized, and discarded. We continue to be monitored, surveilled, targeted, and restricted. Data extraction, deployment, and manipulation have been used to justify and bolster slavery, violence, and anti-Black racism* (2021).

  However, when guided by anti-racist and culturally-informed principles, research and evaluation can be a profoundly important tool for BIPOC and systemically vulnerable groups in telling their stories, including the barriers faced and the performance of MHSUH programs and services (Browne, et al., 2016; FPWC & TPF, 2023; Fante-Coleman, Booker, Craigg, Plumber, & Jackson-Best, 2022; Centre for Addictions and Mental Health, 2021; Fante-Colemen & Jackson-Best, 2020). Several considerations for decolonial and anti-racist evaluations include co-developing evaluation frameworks with relevant communities and using culturally specific research methods and knowledge translation practices (FPWC & TPF, 2023).

  Several communities have organized to advance principles of ethical data governance that should inform the development of anti-racism and equity MHSUH standards. These include the data governance framework called Engagement, Governance, Access, and Protection (EGAP) developed by the Black Health Equity Working Group, and the First Nations data govenance framework of Ownership, Control, Access, and Possession (OCAP®) developed by the First Nations Information Governance Centre (Black Health Equity Working Group, 2021; First Nations Information Governance Centre, 2024). A key throughline connecting these frameworks is self-determination for individuals and communities in shaping data collection, analysis, management, and use. And while there was overwhelming support amongst our participants for these data governance models, we also heard the need to consider the data needs of structurally vulnerable people who do not have the opportunity – often as a result of those same structural barriers – to participate in guiding data collection and evaluation efforts. As one key informant stated bluntly, some people “aren’t in a position to tell their stories because they are dead” and in that instance, systems “have a duty to tell that story” (Key informant interview, 2024).

9. CONCLUSION

This chapter has underscored the pervasive nature of racism within all levels of Canadian society and within MHSUH systems, affecting access, quality, and outcomes of care. Confronting and dismantling racism within MHSUH is not only a moral imperative but also crucial for generating high performing systems and ultimately achieving health equity. To advance anti-racism and equity in MHSUH, standards are an important tool to expand access to culturally-relevant programs and services that respond to the systemic barriers faced by racialized communities in receiving care, expanding access to culturally-relevant programs and services that center the knowledges and values of BIPOC peoples as well as trauma and violence informed practice, and generate a culturally-safe and diverse MHSUH workforce. This report has also highlighted for standards to advance an approach based on working in partnership with BIPOC people and communities in the development, implementation, and evaluation of anti-racism and equity standards.

The places and ways in which BIPOC people experience and are harmed by racism are innumerable. What should be incontrovertible is that the MHSUH systems that are relied on to generate wellness should not be causing more harm. Only through concerted efforts, such as standards development, can we build MHSUH systems that are truly equitable, accessible, and responsive to the needs of all individuals, regardless of their background or identity.

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The Unique Contexts of Substance Use Health: Key Considerations

National Standards for Mental Health and Substance Use Health Services

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We acknowledge the Indigenous Peoples as traditional knowledge keepers, and that our greater society benefits from the sharing of Indigenous Peoples.

We strive for respectful partnerships with all Indigenous Peoples, as we look to do better and search for collective healing and true reconciliation.

Conflict of Interest

The authors do not have any conflicts of interest to declare.

Substance Use Health

When considering aspects of health, it is generally understood that there is a spectrum from well-being to illness on which an individual may find themselves. Their position on this spectrum may change over time and across situations, or it may depend on the aspect of health in consideration. For example, a person's physical health may be considered "good" one day and change abruptly the next day following a diagnosis of a serious illness. Another example is an individual who is considered to be doing "well" overall, but they have a nagging shoulder injury that reappears when they play tennis. This understanding of health is fluid and flexible. It acknowledges the nuances of different life experiences and allows for every individual to hold their own understanding and perception about their physical health.

The use of alcohol and other drugs have not been considered in the same way historically. Knowing the importance of language for driving perceptions and stigma, CAPSA and other key experts have championed the use of the term substance use health. Moving the conversation from focusing only on use and related problems, a substance use health framework acknowledges a spectrum that may include no use at all, beneficial use, use that poses acute or chronic risks, and use that can be categorized as a substance use disorder. None of the components of the spectrum are mutually exclusive. Conceptualizing substance use health in the same manner as we do physical and mental health allows for all people living in Canada to see themselves on this spectrum. This can help address the othering and stigma experienced by people who have been labelled with "addiction." It will also allow for supports to be provided to individuals at any point on the spectrum, facilitating recognition of concerns and intervention before an individual experience's severe levels of harm.

A substance use health framing provides an opportunity for inclusive education, health promotion and service provision, and it will allow for substance use health care to be integrated into services and supports more broadly. Yet, there are components of substance use health that are distinct and which require consideration when developing policy and program responses.

The Unique Contexts of Substance Use Health

Through most of human history people have used substances that alter their physical and mental statuses. They have used them to seek pleasure and euphoria, to make particular emotions or pain "go away," or as part of cultural and social processes. With this use, there is also the potential for harms that have been understood since antiquity.

The substances most used have varied across time and geography, but generally their use has been driven by three important factors: availability, accessibility (or cost) and attitudes (those of society, family, peers). In Canada, substance use includes different layers and approaches to regulation. Substances more commonly used, such as alcohol, tobacco and cannabis, are regulated for personal use. Certain substances are generally authorized for use only in medical or scientific contexts (e.g., benzodiazepines, opioids, stimulants). In addition to societal factors, genetic factors and personal preferences for a given substance, and the presence of underlying conditions such as pain, trauma and mental health concerns may further contribute to substance use prevalence.

Few areas associated with health have been as polarizing or rapidly changing as society's approach to different substances. This is also evidenced by the different strategies used, in terms of policy, social placement and treatment options. The initiative to develop national standards for mental health and substance use health services reflects efforts to address a topic with wide-ranging perceptions and responses, and there is an urgency to adequately address this issue.

The increasingly toxic unregulated drug supply has resulted in very high rates of morbidity and mortality, with the most recent data estimates indicating 22 lives lost per day in Canada during the first six months of 2023 (Federal, provincial, and territorial Special Advisory Committee on the Epidemic of Opioid Overdoses, 2023). Alcohol and tobacco continue to be the top contributors to high rates of mortality (Canadian Substance Use Costs and Harms Scientific Working Group, 2023). Combined with the $49.1 billion costs to the Canadian economy that are related to substance use (Canadian Substance Use Costs and Harms Scientific Working Group, 2023), this topic is deserving of significant attention and action.

Approaches suggested and enacted have been diverse but fall into three broad categories:

1. **Supply reduction:** The use of regulations and enforcement to decrease access or increase cost.
2. **Demand reduction:** Education and health care that focuses on prevention efforts, access to treatment, and other approaches that are aimed at reducing societal use and particularly reducing problematic use.
3. **Harm reduction:** Efforts focused on mitigating or reducing the harms and downstream effects of substance use.

Further complicating efforts to systematically address substance use health are the widely varying patterns of use. Depending on the substance, episodic or more regular use can both produce acute or chronic harms that are not always linked to the severity of someone's substance use or substance use disorder.

Alongside these considerations, substance use health has strong intersections with equity, legal and social factors, and physical and mental health. These intersections must be acknowledged if we are to enact holistic and effective education, prevention, treatment and harm reduction responses.

Distinct Yet Connected to Other Aspects of Health

It is important to recognize that substance use health, mental health and physical health are connected, but caution must be used not to conflate substance use health with mental health. Most people who use substances or experience a mental health concern, for instance, do not have a diagnosed disorder, let alone a concurrent diagnosis.

Yet, there are important links among mental, physical and substance use health that warrant co-ordinated, holistic approaches. For example, people experiencing mental health issues, such as depression, anxiety, personality disorders and psychotic disorders are much more likely to experience concurrent substance use disorders than those without a history of mental health issues (Lev-Ran et al., 2013). Inversely, individuals living with substance use concerns are two to three times more likely to have a past-year mental health disorder than those who do not experience substance use health concerns (Rush et al., 2008). There can also be impacts of substance use health on both short-term and long-term physical health that can result from either episodic or longstanding consumption. These may be positive, such as the use of cannabis to manage symptoms of chronic pain or they may pose a serious threat to health, such as toxicity events and motor vehicle collisions attributable to substance use.

Even acute effects of substance use are increasingly being connected to chronic issues. A nonfatal toxicity event can deprive the brain of oxygen and produce long-lasting but rarely diagnosed brain injury (Kitchen et al., 2021). Chronic use of stimulants can lead to brain changes that persist years after use has stopped (Volkow et al., 2014).

Using substances at lower levels for extended periods of time also has the potential to impact long-term (chronic) physical health. For example, using alcohol chronically increases the risk of developing cancers, such as mouth and oral cavity cancer, esophageal cancer, colorectal cancer and breast cancer, among others (Baan et al., 2007). Also, it is well known that using tobacco over time will increase the risk of lung cancer and other cancers.

The most recent data, collected in 2019, indicated that 76 per cent of people in Canada over the age of 15 years (23.7 million people) had used alcohol, tobacco and other substances in the last year (Government of Canada, 2021). This population can and often does experience health effects directly related to their substance use. For example, 40 per cent of people in Canada who drink alcohol consume more than six standard drinks per week (Statistics Canada, 2021), putting them at an elevated risk of early death from multiple cancers, stroke, heart disease and more (Paradis, et al., 2023). To make informed choices, each person is expected to understand risks and balance the potential harm against any perceived benefit they may experience. And yet substance use is often perceived to be separate from health. For example, of the 25 per cent of people who had reported heavy drinking in the last month, only nine per cent had discussed their alcohol use with their physician (Canadian Institute for Health Information, 2021).

The Current System

In a recent national survey, 83 per cent of people living in Canada reported never having asked their healthcare providers about their substance use. A variety of reasons drove this response, including being unsure of the response they would get, feeling like they could not talk to their provider, and concern about stigma (CAPSA & CCSA, 2024). Uncertainty about how or where to begin a journey toward improved health is a hallmark of a fragmented system. Most substance use health services have been created by peers, charities, nongovernmental organizations (NGOs) and other allies to fill gaps where the needs of those who used substances were not met by the traditional health system. As a result, the system is much more focused on illness than on health promotion and disproportionally set up to treat the downstream effects of substance use,

Increasingly, efforts to address substance use health have been based in evidence and have formed a larger and more visible part of government initiatives. There now exists dedicated ministers of mental health and addictions across many provincial and federal jurisdictions. Also, the renewal of the Canada Health Transfer in 2023 signified a shared commitment between the federal government and provincial and territorial governments toward prioritizing mental health and substance use health services. Beginning in the later 20th century, the science of brain development and advanced imaging of impacts of drugs on brain function (Volkow et al., 2007) have accelerated the research and clinical developments associated with treating substance use. Over the past 20 years, the number of Health Canada–approved medications for treating opioid use disorder or alcohol use disorder have more than doubled. Medical certification bodies and colleges have added addiction medicine or substance use specializations, and there is an increased focus of the healthcare system on addressing these issues.

Despite these advancements, the care a person receives in relation to their substance use health is highly varied and can be largely based on where they live and their ability to pay for private services. In addition to inequitable access, there remains an even less standardized framework for quality of care. Drug-specific care or approach-specific care are often the only two options for individuals, who are left responsible for choosing approaches and self-triaging care. This may include having to self-determine their main concerns or desired outcomes to seek a treatment program for which they will meet admission criteria (e.g., not currently using any substances, not living with any mental health concerns). It can be quite easy to obtain medication for tobacco cessation. However, it can be quite challenging to be offered medication for alcohol cessation and it can require visits to specialized clinics for medications to reduce opioid use.

It would be unthinkable if someone experiencing back pain was expected to diagnose themselves and then choose the most appropriate treatment: surgery, physiotherapy or hospitalization. This is the norm for many people seeking help with alcohol or other drug use.

Varying Regulations, Different Health and Health Service Issues

Another unique consideration related to substance use health is the varying legal landscape surrounding the production, distribution, use or possession of substances. A general legal distinction separates the substances in one of two groups:

- The first group includes alcohol, tobacco and cannabis, which are generally authorized for the public at large, even though each are bounded with certain limits and subject to certain requirements. For example, individuals must be a minimum age to purchase the products and driving under the influence of the substances is prohibited.
- The second group includes substances generally prohibited outside of medical, scientific or other limited circumstances such a supervised consumptions services. These include drugs such as opioids, benzodiazepines and methamphetamines. What is specifically prohibited, required and allowed is specified in the *Canadian Drugs and Substances Act*, the *Foods and Drugs Act*, and a series of regulations and provincial and territorial laws. The substances identified in the *Canadian Drugs and Substances Act* are referred to as "controlled substances."

In public health, it has long been acknowledged that the more policies tend toward both ends of this spectrum — strict prohibition of nonmedical uses and liberal commercialization of all uses — the more risk there is for harms to health at the population level (Beauchesne, 1989; Health Officers Council of British Columbia, 2005)

Three principal issues for the health of people who use substances have been identified with the general approach to "controlled substances." First, the restrictions around nonmedical uses have resulted in the creation of clandestine markets where the participants often use violence to resolve conflicts. Second, these markets have seen substances circulate without any formal controls of their quality, resulting in volatile and even more toxic products than their authorized (pharmaceutical) versions. Third, the imposition of criminal sanctions to people found in possession of these substances has carried important consequences for many people who are presumed to use substances (e.g., employment loss, difficulty in maintaining employment, other forms of social stigmatization). This impacts a person's access to care and the social determinants of their health. If substance use is treated as a criminal offence rather than a public health concern, individuals may hesitate to access treatment and services because they are concerned about legal consequences, such as arrest and incarceration. Instead of receiving appropriate care and treatment, individuals can be subjected to criminal repercussions, often perpetuating a cycle of substance use, criminal involvement and reincarceration (European Monitoring Centre for Drugs and Drug Addiction, 2015). It is also well established that criminalization contributes to stigma toward people who use drugs (Scher et al., 2023).

Changes in perception and science about substance use have driven recent efforts from public health, governments and enforcement to reduce the criminal burden on individuals who use substances including reduced penalties, drug treatment courts and decriminalization efforts. The federal government has acknowledged this overcriminalization with its passing of Bill C-5, which established diversion measures for simple drug possession offences (Government of Canada, Department of Justice, 2023).

In 2022, the federal government adopted a diversion model that maintains the option of drug treatment court for first-time nonviolent offenders, diversion to healthcare services or dismissal of charges (Senate of Canada, 2022). One of the stated objectives of this model is to reduce the inequality that is seen in the overrepresentation of Inuit, First Nations and Métis people; Black, African and Caribbean people; and other equity-deserving populations in Canada’s justice system (Government of Canada, 2023; Ontario Human Rights Commission, 2020).

On the other hand, the main public health issue with the general approach to alcohol, cannabis and tobacco has been the control of their commercialization. Large-scale industrialization and commercialization of these have empowered market operators to increase their use to historical levels, along with associated risks and harms.

The regulation of these substances influences public perceptions of their risks to health and the social acceptability of their use. For instance, the perception of risks from the consumption of alcohol is low, and the social acceptability of its use is high. To the contrary, perceptions of risks from the use of tobacco or controlled substances outside of the medical context is high, and the social acceptability of their use is low. This social acceptability of using a particular substance often determines the acceptability or unacceptability of the persons who use it and the stigma toward them.

Attitudes toward substance use are not static and can change over time. Indeed, there are findings that negative perceptions of cannabis use and stigma toward those who frequently use this substance have declined since legalization in 2018 (Pacheco et al., 2024). The influence of social opinion on substance use can be best observed in relation to tobacco use. Following significant promotion from tobacco companies, smoking tobacco became prevalent in the 1960s and 1970s (National Center for Chronic Disease Prevention and Health Promotion, 2014) and was an accepted part of all social and professional situations. Cigarette use was common in workplaces, restaurants and homes. However, as the negative health consequences of tobacco were established, health promotion and prevention initiatives became widespread and cigarette smoking use steadily declined (National Center for Chronic Disease Prevention and Health Promotion, 2014; Reid et al., 2022). Cigarette smoking has become so unacceptable that it is now banned from most indoor spaces, including hospitals. The toxicity of this substance did not change over the last 70 years, but the acceptability of tobacco use peaked and declined as a result of changing public opinion toward a particular substance. The reduction of tobacco use represents significant emphasis on a whole-of-health and whole-of-government approach that simultaneously tackled availability, access, advertising and the availability of treatment outside specialized settings.

This distinction of public opinion on substances cannot be easily explained by differences in effects or potential harms. In fact, regulated substances account for the majority of substance use in Canada. As a result, the majority of related health harms are also attributed to regulated substances (Canadian Substance Use Costs and Harms Scientific Working Group, 2023). The commercialization and health effects of these substances are often looked at separately. In 2022, tobacco sales totalled $11.8 billion (Statistics Canada, 2023a), while alcohol sales totalled $26.1 billion from April 1, 2021, to March 31, 2022 (Statistics Canada, 2023b). Upon closer examination, alcohol for example, generated $10.9 billion in revenue in 2014, while incurring $14.6 billion in societal costs (Sherk, 2020).

Stigmatization of People Who Use Substances

Individuals living with a substance use disorder face extensive stigma (CAPSA & CCSA, 2024; Chief Public Health Officer's Report on the State of Public Health in Canada, 2019; Fox et al., 2018). Studies show that people living with a substance use disorder are perceived as "dangerous" and "unpredictable" (Mannarini et al., 2015; Hengartner et al., 2013; Mushtaq et al., 2015); are personally responsible for their health conditions (Thege et al., 2015, CAPSA & CCSA, 2024) and morally weak (Mushtaq et al., 2015). The impact of this stigma is profound and often cited as a barrier to seeking help (Cernasev et al., 2021). Stigmatization hinders individuals from accessing necessary services and perpetuates a cycle of shame and secrecy surrounding substance use. This can increase the danger in consumption patterns (e.g., needle reuse, using alone) and the risk of a toxicity event (von Hippel et al., 2018). The ways in which stigma can impact the lives of people who use drugs are extensive.

By name alone, the current umbrella model of "mental health and addictions," which is often how it is referred to in federal, provincial, territorial and community initiatives, screens out people who use substances but who do not have a diagnosis of a disorder. This approach implies that those with a need for substance use health services will only find an open door if they have an "addiction."

Once they even enter care, people may be subjected to stigmatization or abrupt cessation of that care for recurrences of drug or alcohol use. Stigmatization can produce a false narrative attributed to moral failing or lack of effort on the part of the individual. In the broader healthcare system, people are rarely denied treatment or terminated from care for exhibiting the very symptoms that drove them to seek help. Additionally, those providing services are stigmatized for the work they do in supporting individuals who use drugs. This stigma is felt from their families, communities and others working in the healthcare system (Taha et al., 2022).

Services and Supports

Increasing evidence has established the need for a spectrum of care that encompasses a range of services and can be responsive to an individual's self-directed outcome. This spectrum of care should be available and accessible to individuals regardless of the substances they are using. The relevancy of different components of the spectrum may vary depending on an individual's substance use health status. The spectrum should encompass screening and assessment, brief intervention, withdrawal management, pharmacology, psychological interventions and supports for sustaining wellness; harm reduction should be embedded throughout all of these strategies (Taha, 2018). These services should also be available whether the individual is currently experiencing or at risk of experiencing harms from substance use. Although discussed as discrete categories, many of the continuum components overlap in practice (e.g., screening and assessment) and are most effective when used together. Pathways through the continuum are not necessarily meant to be linear. Some individuals might use all components of the continuum whereas others might not, and some might revisit different components as needed (Taha, 2018). A care plan with some or all of these components provides a roadmap that may need to be adjusted to reflect changes in circumstance or personal goals.

Person-Led Care

Person-led care is an approach that considers an individual's specific health needs and desired health outcomes as the guiding principles behind all healthcare decisions (Marchand et al., 2018). Unlike in the broader physical healthcare system, the substance use health system has rarely provided clients the autonomy to choose goals of care or to make informed choices on different approaches. Person-led care represents a more recent change that is both a practice and a way of thinking that sees individuals using health care and social services as equal partners in planning and developing care. It is often referred to as "meeting people where they are at." Evidence shows that individuals are more likely to succeed when setting their own goals based on their needs, as opposed to historically being expected to fit in with the routines and practices that care providers felt are most appropriate (Marchand et al., 2019).

Historically, substance use treatment was largely abstinence based, with success measured in a dichotomous manner as abstinent or not abstinent. This stemmed from the belief that substance use was a moral failing on the part of the individual and that abstinence is the only acceptable outcome of treatment (Crouse, 2022). With the evolution of person-led care and providing treatment for substance use disorder, there has been some realization that despite abstinence working for many people, it is not the goal of all who rely on the spectrum of care for substance use. Wellness can be defined in many ways, including reduced use or reduced harms, either as a step toward cessation or as a goal of its own

Originating with the HIV crisis, harm reduction is an evidence-based, person-led approach to reduce the negative consequences associated with substance use for people who are unable to stop using substances or who do not wish to do so (CATIE, 2022). Harm reduction encompasses a range of health and social services and practices aimed at reducing harms such as toxicity events, blood borne infections such as HIV and hepatitis C, and tissue infection.

Harm reduction strategies may include information on safer use, supervised consumption sites and the provision of needles and syringes. Broader public health interventions such as substance or drug checking and public alerts can be population-level harm reduction interventions. Opioid agonist treatment, the gold standard for treatment of opioid use disorder, began in the 1960s as an alternative to abstinence and a harm reduction program (Fisher, 2000).

Integrated Care

As stated earlier, it is important that substance use health, mental health, and physical health are recognized as connected but distinct (Alford et al., 2016; Canadian Pain Task Force, 2020; Graham et al., 2017). Alcohol use of any amount, for instance, contributes to a multitude of physical health conditions, including cancer, heart disease, liver disease, unintentional injuries, and violence (Paradis et al., 2023). The use of alcohol or tobacco can be related to sexually transmitted infections (Bajaj, 2017). Conversely, physical pain, trauma and stress are known predictors of substance use health concerns. If treated separately, overt symptoms — not underlying causes — are often considered in isolation with significant health and financial impacts. Yet, most people who use substances or experience a mental health concern do not have a diagnosed disorder, let alone concurrent diagnoses. Recent statistics are hard to find, but when assessed in 2012, only 1.2 per cent of people living in Canada had a diagnosed concurrent disorder (Khan, 2017). This indicates that the provision of only concurrent services is not the sole solution.

The impacts of these co-occurrences touch on all aspects of health. Barriers exist that fail to recognize the interrelations between these concerns, such as having to be abstinent before accessing mental health services or not being eligible for heart surgery due to intravenous drug use. Effective care for individuals along the spectrum of substance use health must be embedded within the broader context of all aspects of health to observe meaningful change in the well-being of people living in Canada.

Even when meeting these criteria, substance use health services and supports are disparate across the country, with extremely limited availability in rural and remote areas. Alongside these factors, there is the provision of both public and private substance use healthcare in Canada. This creates a two-tiered system in which individuals who can afford to pay for services can get access, while those who cannot afford to pay must wait (Russell et al., 2021). Yet there is limited regulation on substance use healthcare services. So, even those who pay for private facilities have no guarantee about the quality or effectiveness of the care they receive. Private treatment can lack oversight and accountability mechanisms, which can result in the use of non–evidence-based programming that further harms people accessing services (White & McLellan, 2008). Further, government programs, often intended to serve the most disadvantaged (Palepu et al., 2013), are underfunded and understaffed and have long wait times (Anderssen, 2020).

Of great importance are the individuals with lived or living experience, sometimes referred to as peers or mutual aid. These individuals have taken on the role of service providers where care has otherwise been ignored. Peer support is built on the premise that shared life experiences benefits both the receiver and the helper (Tracy & Wallace, 2016). The relationship has been linked to an increase in empowerment, hope and connectedness to a community. This nonclinical assistance is provided by individuals with similar conditions or circumstances and helps achieve movement toward well-being (Tracy & Wallace, 2016).

Often functioning as caregivers or informal case managers, family[1] and friends also play an integral role in a person's substance use health (BC Centre on Substance Use, 2018; Hadland et al., 2021). Having a positive caregiver relationship for an individual is a protective factor against substance use initiation and progression (Rowe, 2012). Caregiver involvement in substance use treatment and care also promotes greater engagement in treatment, as well as more positive treatment outcomes.

Despite the integral role that family and friends can play in supporting a person's substance use health, existing care models often neglect to consistently engage family members as supportive allies in care (Bagley et al., 2021). Additionally, caregivers face significant barriers to supporting their loved one's substance use health, including a lack of resources, education and tools on navigating health systems; an inability to access to critical information on their loved one's health; and experiences with stigma (Bagley et al., 2021; Marchand et al., 2022). This often results in their exclusion from their loved one's treatment and care (Kourgiantakis & Ashcroft, 2018).

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[1] Family is defined broadly and includes but is not limited to partners, spouses, siblings, friends, adult children and parents.

Opportunities

There is a need for a range of supports and services that span the entire spectrum of substance use, where multiple sectors have a role and people can access care that responds to their desired goals. Ideally, these services would be housed under one roof. Excluded from much current work are discussions about the health benefits and risks of substance use (CAPSA & CCSA, 2024). There is an inbuilt assumption that people's current substance use health status will be static and that those who do not use substances currently will not use in the future. This has significant implications for missed prevention, education and intervention opportunities.

A substance use health framework (CAPSA, 2020) provides a starting point for the provision of health promotion, information and services across a spectrum of substance use for all people living in Canada. Like mental health and physical health, this framework requires a broad lens of health that *includes illness*, not a lens of illness that *excludes health*. The idea is to create a shared and inclusive language of substance use health, not only specialized and separate language for people with "addictions" — and in the process reduce stigma and othering.

While the Mental Health and Substance Use Health Standardization Roadmap focuses on treatment services, there is a unique opportunity for the healthcare system to reframe how it approaches substance use health services and supports. Discussions around substance use should begin earlier — before an individual reaches higher-risk use or meets the criteria for a substance use disorder. By approaching the issue of substance use health with greater proactivity, we can reduce some of the personal, social, economic and healthcare costs attributed to substance use (Canadian Substance Use Costs and Harms Scientific Working Group 2023).

Models are starting to emerge that are more explicit on health promotion and prevention, such as stepped care solutions (Cornish, 2023) and needs-based planning (Rush et al., 2008). However, the current practical entry point for substance use health care begins at sickness, and services and supports diminish as people become healthier or consider themselves to be healthy already.

No one intervention on its own can address the complexity of substance use health and the related harms. True change requires a reconceptualization of the way we look at substance use and the healthcare system's role in responding to concerns that encompasses all the unique considerations laid out in this chapter.

A comprehensive, multisectoral approach is needed. This includes investing in a continuum of social and health services, and through co-leadership, applying the expertise of people with lived and living experience of substance use. To ensure that solutions are effective and do not inadvertently perpetuate stigma or other harms, people with lived or living experience are needed to co-develop this continuum.

Decades of research have demonstrated that effective prevention efforts and even treatment must look at the whole person and their environment (Foxcroft & Tsertsvadze, 2012). Communities have a significant role to play in developing these healthier environments and supporting families in building skills and hope.

Taken together, these considerations present an opportunity to improve outcomes regarding the substance use health of individuals living in Canada. Providing holistic, evidence-based, anti-oppressive, antiracist and person-centred care for people across the spectrum of substance use health will increase equitable access to quality services and supports. This presents a complex yet appealing opportunity to standardize care within the health system, and because of the relations to other sectors, it also presents an opportunity to standardize care in multiple realms. Regardless of the approach, what is most critical is the inclusion of a diversity of people whose voices have traditionally been excluded to occupy positions of co-leadership in decisions that impact them.

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Mental Health and Substance Use Health Accreditation Recommendations Report

March 2024

Prepared by: Health Standards Organization

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Foreword

SCC Foreword

The Standards Council of Canada (SCC) is a Crown corporation within the portfolio of Innovation, Science and Economic Development (ISED) Canada. With the goal of enhancing Canada's economic competitiveness and social well-being, SCC leads and facilitates the development and use of national and international standards and accreditation services. SCC advances Canada's interest on the international scene as a member of the International Organization for Standardization (ISO) and International Electrotechnical Commission (IEC).

As Canada's leading accreditation organization, SCC creates market confidence at home and abroad by ensuring that conformity assessment bodies meet the highest national and international standards. Accreditation services are provided by SCC to various customers, including product certifiers, testing laboratories, and standards development organizations. A list of SCC programs and accredited bodies is publicly available at www.scc.ca.

CE RAPPORT EST DISPONIBLE EN VERSIONS FRANÇAISE ET ANGLAISE.

HSO Foreword

Health Standards Organization (HSO) and our affiliates Accreditation Canada (AC) and the Institute for Quality Management in Health Care (IQMH) are global, not-for-profit organizations united by a vision for safer care and a healthier world. HSO's people-centred programs and services have been setting the bar for quality across the health ecosystem for more than 60 years.

HSO develops standards, assessment programs and quality improvement solutions that have been adopted in over 12,500 locations across five continents. HSO is the only Standards Development Organization dedicated to health and social services. Global standards developed by HSO meet the requirements of the International Society for Quality in Health Care (ISQua), and our National Standards are recognized by the Standards Council of Canada (SCC). All HSO standards and programs are shaped by evidence and experts, including people with lived experience.

Third-party Support

Throughout this project, Health Standards Organization used two third-party organizations to support the research. The third-party support was used to ensure an objective and impartial approach to the collection and analysis of findings and development of recommendations.

BoardWalk Group supported project management, conducted the literature review and environmental scan, and supported the strategic direction of the project.

Exult Experience Design led the engagement work, including in-depth interviews, online survey, and small group discussions. This approach ensured a neutral third party was conducting the engagement activities and ensured confidentiality of respondent results.

Key Insights

The qualitative and quantitative insights gathered from knowledge holders were perspectives and perceptions, and not tied to any quantitative outcomes. The online survey sample included representation from individuals with experience or knowledge of the MHSUH field. This should not be considered a representative survey of the total population.

Executive Summary

In 2022, the Standards Council of Canada launched the National Mental Health and Substance Use Health (MHSUH) Standardization Collaborative, which is a forum that facilitates input from a diverse group of interested parties. The Collaborative developed a Standardization Roadmap to identify future opportunities for advancing MHSUH service delivery and treatment outcomes nationwide. It will serve as a guiding framework for the formulation of collectively established rules, guidelines, and characteristics, ensuring the quality and accessibility of MHSUH services and programs.

As part of this work, SCC partnered with HSO to evaluate the needs and opportunities for related conformity assessment schemes and accreditation programs for MHSUH. The outcomes of this assessment will complement the roadmap. As an integral part of this initiative, comprehensive research, evidence review, and extensive engagement—including interviews, surveys, and discussions—were conducted with people with lived and living experience and expertise, Indigenous leaders and representatives, health and social service providers, government, not-for-profit organizations, researchers, academics, and accreditation bodies. The objective of this engagement was to identify perceived strengths, limitations, and potential improvements in the accreditation and conformity assessment processes.

Throughout these engagements, there was a clear sentiment that accreditation and conformity assessment can play a key role in enhancing MHSUH care. Respondents emphasized accreditation's role in enabling quality care, driving continuous improvement, bolstering organizational reputation, enhancing safety, promoting standardization, and serving as a benchmark for best practices. However, the conversations also revealed notable perceived limitations of accreditation, including inadequate representation from communities and diverse individuals, high resource and financial costs, overly complex and resource-intensive programs, insufficient oversight leading to superficial implementation, cultural safety, and health equity gaps, and a lack of emphasis on health outcomes.

Recommendations aim to address the identified limitations identified in this report are outlined and include:

1. Importance of client-centric collaboration
2. Maintaining timely and relevant standards and accreditation programs
3. Cultural safety and sensitivity of standards and accreditation programs
4. Optimized accreditation process
5. Increase knowledge and understanding of standards and accreditation
6. Accreditation as a lever for building a culture of quality and safety
7. Focus on integrated care in standards and accreditation programs
8. Reducing barriers to implementing accreditation programs

These recommendations lay the groundwork for transforming the MHSUH sector, addressing challenges, and fostering a more client-centred, inclusive, and responsive system.

Introduction and Background

Mental Health and Substance Use Health in Canada

Mental illness affects some 1.2 million Canadian children and youth. One in five Canadians is affected by age 25.[1] In 2020, substance use in Canada cost more than $49 billion, led to more than 270,000 hospitalizations, and contributed to the loss of nearly 74,000 lives.[2] Over the last few years, the COVID-19 global pandemic has pushed the already strained MHSUH system to the brink. It has highlighted gaps in services and issues with equitable access to treatment that need to be addressed urgently.

A 2021 survey indicated that the rate of Canadians over the age of 18 who experience symptoms of depression, anxiety, or post-traumatic stress increased from approximately one in five to one in four between fall 2020 and spring 2021.[3] Furthermore, over the course of an average Canadian's lifetime, rates of substance-use disorders were higher than the rates for mood disorders in Canada.[4]

The combination of increasing rates of mental illness and substance use, acuity and service disruption has exacerbated the already stretched system and workforce. This is causing significant pressures on the health and social care systems, resulting in challenges in access to care, fragmented and disjointed care, significant variability in the quality of care, and many Canadians living with unmet needs. This difficult time has highlighted the need to address long-standing gaps in the delivery of mental health and substance use services across the country.

Standards Council of Canada's Mental Health and Substance Use Health Standardization Collaborative

Standardization is crucial in improving the quality of MHSUH services across Canada. It ensures consistency in care delivery, regardless of the location or provider, and ensures that challenges around equitable access to high-quality care are visible. By establishing common standards, health care organizations can benchmark their services against nationally recognized criteria, promoting a uniform level of care quality. Standards serve as a foundation for best practices, enhancing patient safety, efficacy, and access to care.

Accreditation plays a key role in bringing standards to life. It assesses organizations against these established standards to ensure they meet specific quality and performance criteria. This process encourages continuous improvement, innovation, and accountability among MHSUH service providers, ultimately leading to better health outcomes for people accessing these services. Accreditation also builds public trust in MHSUH services, indicating that an organization is committed to maintaining high standards of care.

In March 2022, the Government of Canada announced that it would be working with the Standards Council of Canada (SCC) to develop standards-based deliverables to help improve the quality of MHSUH services. In addition, SCC launched the National MHSUH Standardization Collaborative, which engages a diverse range of key partners to inform the development of a MHSUH Standardization Roadmap.

The MHSUH Standardization Roadmap describes the current and desired standardization outcomes for Canadian MHSUH services, including recommendations to address gaps and issue areas where standardization is needed.

Parallel to the development of the MHSUH Standardization Roadmap, SCC has partnered with contracted organizations to complete six standards-based deliverables on priority topics:

- Primary Health Services Integration
    - Integration of MHSUH in primary care settings
    - Digital MHSUH apps
- Children and Youth
    - Integrated Youth Services
- People with Complex Needs
    - Integrated services for people with complex needs (Early Psychosis Intervention)
    - Substance use health treatment centres (withdrawal management)
    - Substance use health workforce competencies

To complement the MHSUH Standardization Roadmap and the six standards-based deliverables, the Standards Council of Canada partnered with Health Standards Organization to evaluate needs and opportunities for related third-party review and evaluation programs to develop recommendations for the future.

Project Objectives

The primary objective of this project is to delve into the practical implementation of standards-based deliverables through accreditation and conformity assessment processes, with a specific focus on MHSUH. Addressing the broader landscape of MHSUH and its six priority areas, the project aims to generate a set of recommendations provided through knowledge holder input that will serve as a foundational guide for the implementation of standards-based deliverables, thereby supporting standardization within the MHSUH field. In particular, the recommendations in this report will:

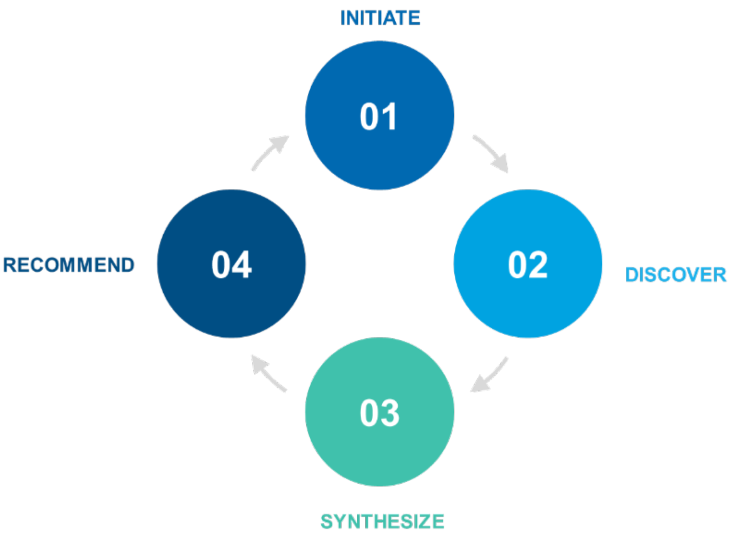
- Complement the MHSUH Standardization Roadmap.
- Address complex questions surrounding standardization in the context of MHSUH.
- Guide the allocation of resources for active participation in the planning and development of standards and related research activities within the MHSUH domain.
- Analyze the existing Canadian standardization landscape and articulate the desired state.
- Provide targeted recommendations to bridge gaps and identify novel areas where standards and conformity assessment are essential for MHSUH.

It is important to note that this report reflects the subject matter expertise of those who participated in its development. This is not a consensus-based document, but a reflection of diverse perspectives and experiences.

Approach and Methodology

Phased Approach

This project involved a phased approach. The four phases are identified as: Initiate, Discover, Synthesize and Recommend.



We began the **Initiate phase** by holding kickoff meetings with various project teams, including Standards Council of Canada, and the MHSUH Collaborative Steering Committee. We established the MHSUH Collaborative Steering Committee as advisors. We also partnered with Hill and Knowlton to engage with people with lived and living expertise and designated support persons; and with Firelight Group to engage with First Nations, Métis, and Inuit people. These steps were taken to minimize respondent burden, fatigue and duplicative data and efforts.

We then launched the **Discover phase**, which involved conducting a literature review, environmental scan, in-depth interviews, surveys, and small group discussions with knowledge holders, including people with lived and living expertise and Indigenous experts across all groups, and health and social service providers, interest groups such as not-for-profit organizations, researchers and academics, and accreditation bodies.

In the **Synthesize phase**, we presented results at the Jan. 30, 2024, MHSUH Standardization Collaborative Government Advisory Table and at the Feb.13, 2024, MHSUH Steering Committee. We described the findings of our Discover phase, focusing on the emerging recommendations stemming from knowledge-holder wisdom. We then synthesized and validated these recommendations with the Steering Committee.

Finally, using the feedback from the Synthesize phase, we refined and summarized our findings in the **Recommendations phase**. We drafted the Recommendations Report and submitted it to multiple interested parties for review.

Recommendation Report Overview

This project involved developing a Recommendations Report to serve as the foundation for implementing the standards-based deliverables, supporting standardization in the field of MHSUH, and understanding nuances in the six priority areas and MHSUH in general. In terms of scope, this Recommendations Report focuses on achieving the following objectives:

1. A review of the **current state** of health service provider accreditation bodies internationally, nationally, and in the MHSUH space.
2. A **literature review** of MHSUH health service provider accreditation, including perspectives on health service provider accreditation, impacts, challenges, barriers, facilitators, considerations in the 6 priority areas, and for Indigenous health organizations.
3. Describe **insights from engagement activities** including a national survey, in-depth interviews, and small group discussions with a variety of knowledge holders.
4. Develop **recommendations** for health service provider accreditation in the MHSUH sector.

Understanding Standards, Accreditation and Conformity Assessment

Standards

What are standards?

A standard is a document that provides a set of agreed-upon rules, guidelines or characteristics for activities or their results.[5] Standards establish accepted practices, technical requirements, and terminologies for diverse fields[6]. They can be voluntary or mandatory, and are distinct from laws, regulations, and codes, although standards can be referenced in those legal instruments[6]. High-quality standards are people-centred, evidence-based, relevant, and responsive to current and future needs.[6] Standards help answer the question: “What is the best way to do this?”, and their impact is indicated by widespread adoption and use.

Role of Standards in Quality Improvement

There is global recognition that standards help health systems develop and improve important topics such as governance, leadership, infection prevention and control, and medication management — which all affect the quality of services that the public receives.

Standards create a strong health care structure that the public, providers, and policy-makers can rely on, assuring high-quality health services where it matters most.

Standards help health service providers:

- Improve the quality of health services
- Determine what type of care should be offered and identify gaps in their current systems
- Improve health and safety in the workplace
- Identify best practices, leading to reliable and higher-quality health services for the public in local jurisdictions
- Find efficiencies

Standards help the general public to:

- Know what level of quality to ask for from their service providers
- Actively provide feedback on current health services deliverability and help identify gaps
- Have confidence that the health services they are receiving are standardized, meaning they’re verified, safe and reliable
- Put a human face to health services — clients can see their local health organizations actively working to improve care

Accreditation and Conformity Assessment

What is Accreditation and Conformity Assessment?

In the standardization field, accreditation refers to formal, third-party recognition by an independent body (generally known as an accreditation body, such as the Standards Council of Canada) that an organization is competent to perform specific tasks – the work for which they are accredited[7]. It can be voluntary or mandated by the government. It is a continuous quality improvement process to demonstrate that internationally and/or nationally prescribed standards have been met. Distinctly, conformity assessment is the practice of determining whether a product, service, or system meets the requirements of a particular standard.

Throughout this report, the term “accreditation” is used in a manner customary in the health care sector; it can be interpreted to mean” conformity assessment plus continuous quality improvement.”

In relation to health service providers, “accreditation” refers to a formal, independent, third-party assessment conducted by expert peer surveyors against quality standards. Accreditation bodies such as CARF, Accreditation Canada, Canadian Accreditation Council, and the Canadian Centre for Accreditation, conduct accreditation of organizations, systems, programs, and services, to ensure they meet the requirements of quality standards. Health and social services organizations leverage accreditation to gain recognition for their commitment to a continuous process of improving the quality of their services.

Health care service providers use the term “accreditation” in a way that is comparable to the definition of “conformity assessment” within the standardization field. Both terms refer to a process that determines whether a program, service, organization, or system meets the requirements of a particular standard. The health care concept of “accreditation” additionally involves continuous quality improvement; for example, surveyors may provide suggestions for improving a given program, service, organization, or system.

Health service provider accreditation can be at the organization or program level.[8,9]

- **Organization-level accreditation** typically applies to health care institutions including hospitals, clinics, and health care systems. This process ensures that the entire organization meets certain standards and criteria related to client care, safety, and administrative practices.
- **Program-level accreditation** focuses on evaluating specific health care programs, departments, or services within a health care institution to ensure they meet industry or professional standards. This process ensures that these specialized areas within the health care organization provide high-quality care, adhere to best practices, and maintain the highest standards in their respective fields.

The following table describes the phases of health service provider accreditation, as defined by the International Society for Quality in Health Care (ISQua). It provides information on the core components of health service provider accreditation, such as peer review surveyors travelling to an organization for an on-site survey.

Phase	Description
Apply	Organization seeking to be accredited completes an application
Survey Preparation	Organization seeking to be accredited prepares application documents for surveyors
Technical Review	Organization submits documents to Accreditation Body for technical review. Technical review report is sent from Accreditation Body to the organization.
Final Submission of SAT	Organization submits final completed self-assessment tool and supporting evidence.
Survey	Peer review surveyors travel to the organization for an on-site survey. This includes assessing compliance, identifying improvements, generating reports, and providing recommendations.
Factual Accuracy Review	Organization is given opportunity to undertake factual review of draft survey report
Validation Review	Surveyors survey report is sent to organization for validation
Award Decision	Survey team provides recommendations and/or award decision from the accreditation body
Continuous Assessment	Organization completes submission of progress reports to enable continuing accreditation status
Re-Accreditation	Accreditation body contacts organizations periodically to schedule re-accreditation

Standards Council of Canada: Standards and Accreditation

Role of Standards Council of Canada in Standards

The Standards Council of Canada accredits standards development organizations and represents Canadians at the International Organization for Standardization (ISO) and the International Electrotechnical Commission (IEC). The Standards Council of Canada also reviews standards submitted by standards development organizations for approval as National Standards of Canada (NSCs). Through its Member Program, SCC also coordinates membership on international standards development committees. The sections below provide more detail on the process for the development of the National Standards of Canada as well as international standards.

Development of National Standard of Canada

The development of NSCs makes use of international standard development best practices and safeguards the interests of Canadians. NSCs may be nationally developed or may be adoptions of international standards. When developing NSCs, SDOs consider important factors such as timing, funding, and committee structure.

Steps in the NSC development process include:

- Identifying the need for the standard
- Reviewing the existing standards landscape
- Engaging affected knowledge holders
- Notifying the public at the project start
- Developing the standard (by technical experts)
- Publicly consulting on the proposed standard
- Disposition of comments and revision as applicable by the technical committee
- Vote and approval of the NSC
- Prompt publication
- Maintenance of the NSC

To be recognized as a National Standard in Canada, the standard must be developed in accordance with the Requirements and Guidance — Accreditation of Standards Development Organizations. Key requirements include, but are not limited to:

- Development by consensus from a balanced committee of knowledge holders
- Public scrutiny
- Publishing in both of Canada’s official languages
- Being consistent with (or incorporating) existing international and pertinent foreign standards
- Not acting as a barrier to trade
- Maintenance, generally through periodic review (five-year cycle) or as changes are needed

The periodic review can result in confirmation that the technical content is still valid or a revision or withdrawal of the NSC. This is done to ensure the ongoing relevance and currency of standards.

Role of Standards Council of Canada in Accreditation

Accreditation is a formal, third-party recognition that an organization is competent to perform specific tasks — namely, the work for which it is accredited. Accreditation can be voluntary or mandated by the government. It is a process that involves continuous quality improvement while demonstrating that internationally and/or nationally prescribed standards have been met.

The SCC is Canada’s National Accreditation Body. It accredits conformity assessment bodies, such as testing laboratories and product certification bodies, to ensure they meet internationally recognized standards, such as the ones from ISO and IEC. Conformity assessment is the practice of determining whether a product, service or system meets the requirements of a particular or a group of standards. Accreditation by SCC establishes confidence in the services delivered by certification bodies.

The SCC is well respected in Canada and around the world and consistently delivers high-quality and rigorous accreditation services. As a member of and signatory to the International Accreditation Forum (IAF), the International Laboratory Accreditation Cooperation (ILAC), the Asia Pacific Accreditation Cooperation (APAC), and the Inter-American Accreditation Cooperation (IAAC), SCC can assess according to the ISO standards and is subject to regular evaluation itself. These agreements are part of greater efforts to form a global accreditation system, consistent with the goal of “one standard, one test — accepted everywhere.”

Standards Council of Canada Accreditation Programs

SCC does not complete conformity assessments of health service providers (or “accreditations,” as they’re more commonly known in the health sector). SCC offers accreditation and recognition programs for the following:

- Management systems certification bodies
- Product, process, and service certification bodies
- Inspection bodies
- Greenhouse-gas validation/verification bodies
- Professional certification bodies
- Standards development organizations
- Testing and calibration laboratories
- Medical testing laboratories
- Proficiency testing providers
- Good Laboratory Practice (GLP) facilities

Current State of Health Service Provider Accreditation

Current International Health Service Provider Accreditation Bodies

There are several accreditation bodies internationally. Some examples include the Joint Commission in the United States, Accreditation Canada in Canada, and Australian Council on Healthcare Standards in Australia. This is not an exhaustive list. These organizations vary based on the types of programs offered, and jurisdictions differ on whether accreditation is mandatory or voluntary. The table below provides an overview of the literature on accreditation internationally.

Country	National Accreditation Mandatory or Voluntary	Implementation	Process
Across Europe[10]	National accreditation is well developed and is mostly mandatory across Europe; some European countries are still in process of developing their national accreditation systems or have decided to keep it voluntary	One-third of accreditation programs are run by governments, one-third are independent, and one-third are hybrids	Programs vary widely, there is a need for a common approach to the definition, assessment, and improvement of standards in health care
United Kingdom[11]	National Accreditation is Voluntary	There are several Accreditation Bodies, such as the Hospital Accreditation Program and the King's Fund Audit	The process varies by accreditation body. Lack of an accredited system has resulted in several accreditation systems administered by regional authorities
France[12]	National Accreditation Mandatory. International Accreditation is Voluntary	Single dominant accreditation body – National Health Authority	Health care organizations must be accredited every four years. Criteria and accreditation reports are publicly available on the National Health Authority website
Italy[13, 14]	National Accreditation Mandatory; International Accreditation is Voluntary	National Accreditation is Mandatory and is implemented by each region.	Health care organizations must be accredited every four years. Each region can implement its own accreditation system based on Ministry's guidelines. National accreditation system can be only implemented by the state. Private organizations that want to have contracts with regional authorities, need to go through the accreditation process as well
Spain[15 ,16,17, 11]	Mixed. Mostly voluntary, but mandatory for health care institutions seeking contracts with regional health authorities	The national accreditation system is provided mainly by SECA; regional authorities can also play a role, especially in autonomous regions. International accreditation can be provided by several accreditation bodies (e.g. JCI is popular among main private groups)	The validity is between 3 and 5 years, depending on the accreditation body
United States[18,19]	Voluntary	Involves several Accreditation Bodies such as the Joint Commission on Accreditation of Health Care Organizations and the Accreditation Association for Ambulatory Health Care	Involves regular surveys of the organization's performance by the accrediting agency, to ensure quality of care provided to clients. This process ensures facilities meet nationally accepted standards through a recognized accreditation program

Australia[20, 18]	Mandatory – All public and private hospitals must be accredited against the National Safety and Quality Health Service Standards.	Single dominant accreditation body: Australian Commission on Safety and Quality in Health Care	Involves an on-site visit by surveyors who are independent of the health service. Completed against standards. This process generally occurs every 3 years
New Zealand[21]	Mixed	Two Accreditation Bodies approved by the Ministry of Health, the Joint Accreditation System of Australia and New Zealand and the International Society for Quality in Health Care (ISQua)	Varies based on accreditation body

International Accreditation Bodies with MHSUH Programs

In the international landscape, MHSUH accreditation programs are often referred to as “behavioural health” programs. To our knowledge, there are few accreditation bodies with specialized behavioural health programs. More typically, MHSUH organizations simply fit within general portfolios. Some examples of specialized behavioural health programs are listed below.

- CARF International has a behavioural health program which uses a holistic, person-centred quality framework of standards. These reflect leadership in the field internationally through the promotion and advancement of programs and services for integrated behavioural health, mental health, substance-use disorders, addictions, psychosocial rehabilitation, and family services[22].
- Another U.S. example is the Joint Commission’s behavioural health care accreditation and certification programs, including Accreditation for Opioid Treatment Programs, Behavioral Health Home Certification, and Disease-specific Care Certification.[23] The (U.S.) Accreditation Commission for Health Care (ACHC) also has a behavioural health accreditation program focusing on mental health, substance use health, residential treatment, and other options, involving expert surveyors in behavioural health.[24]
- Council on Accreditation (COA) is an international, independent, non-profit organization offering accreditation to the full continuum of behavioural health, child welfare, and community-based social services, including opioid treatment programs.[25]

Canadian Accreditation Bodies with MHSUH Programs

In Canada, there are several accreditation bodies and accreditation is generally voluntary. Four accreditation bodies have MHSUH programs: Canadian Centre for Accreditation (CCA), Accreditation Canada (AC), Commission on Accreditation of Rehabilitation Facilities (CARF), and Canadian Accreditation Council (CAC).

Canadian Centre for Accreditation (from https://canadiancentreforaccreditation.ca)

CCA is a national not-for-profit organization that provides accreditation tailored to community-based health and social services across Canada. CCA assesses organizations using a four-year accreditation program against standards covering governance, organizational planning and performance, leadership, and risk management. CCA uses two types of standards: mandatory standards and learning practice standards. To be accredited, an organization must meet all mandatory standards that are applicable and a certain number of applicable leading practice standards. This process supports quality and is conducted by a trained team including senior staff, governing body members, and volunteers from the community-based organizations that participate in CCA. An annual quality update, every four years, represents an opportunity to review preliminary results and provide additional evidence.

CCA offers a Community Mental Health and Addictions program targeted toward a range of community mental health services and community addiction services, including those delivered in a residential setting or as part of supportive housing. It involves standards specific to mental health and addictions programs and services, addressing mental health promotion in the broader context of social determinants to health; the organization's approach to service; and aspects of the service process, such as how continuity and coordination of services are assured and personnel, including peer counsellors, are supportive. CCA's standards in community mental health and addiction services are developed and updated with input from leaders and experts in the mental health and addictions sector.

Accreditation Canada (from: https://accreditation.ca/)

Accreditation Canada is an international non-governmental not-for-profit organization that assesses organizations against global standards to improve the quality of health and social services in Canada and globally. AC works with expert peer surveyors with health care and social services experience trained in AC's customized, continuous assessment Qmentum Accreditation program. AC provides accreditation to large networks, health systems, long-term care, small-home care, community health centres, and primary care organizations. Its Qmentum program uses evidence-informed standards developed by Health Standards Organization, endorsed by SCC as National Standards of Canada.

Accreditation Canada's e-store offers two MHSUH standards, the Mental Health and Addictions Services standard and the Suicide Prevention Program standard. These standards help organizations assess quality at the point of service delivery and embed a culture of quality, safety, and client- and family-centred care. The standards are based on five key elements of service excellence: clinical leadership, people, process, information, and performance. The Mental Health and Addictions standard is structured into the following sections: Client-centred Care; Respecting Client Rights; Delivering High-Quality Mental Health Care and Addictions Care Based on the Goals, Abilities and Preferences of Clients; Ensuring Continuity of Mental Health Care and Addictions Care; and Enabling a Healthy and Competent Workforce (Health Standards Organization, 2023). The Suicide Prevention Program standard outlines the ingredients for a comprehensive suicide prevention program, including routine screening for suicide risk, assessment of suicide risk, safety planning, care planning and treatment, and postvention services (Health Standards Organization, 2023).

Commission on Accreditation of Rehabilitation Facilities (CARF) (from https://carf.org)

CARF International is an independent, non-profit accreditation and standards-setting organization founded in 1966. CARF International is a group of companies that includes CARF Canada and CARF Europe; together they accredit more than 9,000 organizations across five continents. CARF's mission is to promote the quality, value, and optimal outcomes of services through a consultative accreditation process and continuous improvement of services that centre on enhancing the lives of people served. CARF develops and maintains field-driven, international consensus standards for behavioural health, child and youth services, employment and community services, aging services, and medical rehabilitation.

Territories and provinces across Canada recognize and approve CARF as an accreditor. This includes but is not limited to the Alberta Ministry of Health recognizing CARF as an accepted accrediting organization for continuing care, seniors' care, and mental health and addictions. In British Columbia, the Ministry for Children and Family Development, Community Living B.C. and the First Nations Health Authority have approved CARF as an accreditor for behavioural health programs. CARF is also approved by the American Society of Addiction Medicine to certify, assess, and verify residential substance-use disorder treatment services.

Canadian Accreditation Council (CAC) (from https://www.canadianaccreditation.ca/)

The Canadian Accreditation Council is a national non-profit organization that accredits human service organizations across Canada. CAC has been accredited by the International Society for Quality in Health Care (ISQua) through the ISQua External Evaluation Association. Its standards are reviewed and updated every four years. To develop standards, CAC works with groups of knowledge holders to understand and develop standards that reflect the needs of the people in the accredited programs. CAC is currently celebrating 50 years of accreditation services.

CAC accredits the following programs: addictions programs; adult, child, youth, and family programs and organizations; community health and wellness centres; employment programs; homelessness and shelter programs; Indigenous programs; mental health; nursing stations; and seniors' health care. CAC's accreditation process evaluates governance, practice, and outcomes. CAC created an enhanced designation to ensure there is additional training in the area of addictions and the medical and clinical support required to operate this type of service. CAC's standards for mental health programs address various capacities, including relating to others, handling stress, evaluating challenges, and pursuing goals.

Current Accreditation Status of MHSUH Organizations

In the United States, data from the Substance Abuse and Mental Health Services Administration (SAMHSA) 2019 report on mental health treatment facilities have shown that of 12,472 facilities identified 8506 were accredited (68.2%).[26]

- Residential treatment centres, 64% were accredited
- Public and private psychiatric hospitals, 80% were accredited
- Community mental health centres, 60% were accredited
- Facilities that serve children and / or adolescences, 60% of facilities were accredited.

Accreditation bodies included CARF, the Joint Commission, and the Council on Accreditation.

While no comparable studies have been published in Canada or elsewhere, the World Health Organization Psychiatric Services report suggests that these numbers would be much lower for low- to middle-income countries, with one-third of all countries having no mental health policy or plan.[27]

An international report on the International Initiative for Mental Health Leadership Clinical Leaders Project identified 38 organizations with mental health quality measurement programs. Of these, 64% presented individualized quality or performance data about participating care providers or organizations being measured.[28]

The significant variation in the proportion of organizations that have adopted standards and accreditation in the international context indicates the need for recommendations on the barriers and opportunities around accreditation, to enable more organizations to become accredited, thereby improve standardization.

Accreditation for Indigenous Health Organizations in Canada

The Government of Canada First Nations and Inuit Health Accreditation Program recommended that Indigenous Services Canada support the voluntary accreditation of health services provided at First Nations community health centres and First Nations and Inuit Health Branch nursing stations. Indigenous Services Canada also supported the accreditation of the National Native Alcohol and Drug Abuse Program and Youth Solvent Abuse Program treatment centres. Accreditation is voluntary for non-transferred treatment centres and mandatory for transferred (designated by relevant authorities or regulatory bodies to undergo the accreditation process) treatment centres.[29]

Several accreditation bodies and standards organizations have standardization approaches for Indigenous health organizations.

- The Canadian Accreditation Council has specific Indigenous programs and is committed to working in collaboration with First Nations communities to enhance programming through the process of accreditation.[30] CAC has released standards supporting ongoing learning about Indigenous history and culture, access to resource people, and providing positive role models[63].
- Health Standards Organization released the British Columbia Cultural Safety and Humility Standard, which is focused on helping governing body members and organizational leaders identify, measure, and achieve culturally safe systems and services that better respond to the health and wellness priorities of First Nations, Métis and Inuit peoples and communities, regardless of where they are located.[31]
- Accreditation Canada's accreditation program for Indigenous Health and Social Services was co-designed with the First Nations and Inuit Health Branch, the First Nations Health Authority in British Columbia and the First

Nations Health Managers Association.[32] Indigenous-specific standards cover the areas of governance, leadership, infection prevention and control, community health and wellness, integrated primary care, substance use health services, and health services for remote/isolated communities.[32]

- In 2014, the Canadian Centre for Accreditation developed Indigenous-informed approach standards, based on interest from partners who wanted CCA to augment its standards to reflect expectations for service being provided to Indigenous people.[33] The framework used to implement these updates recognizes Indigenous rights to determination, the role of Indigenous knowledge, value systems and approaches to inform planning and practice. It focuses on the restoration and rebalancing of the physical, mental, emotional, and spiritual well-being of people, families, communities, and nations through all stages of life.[33]

A report by the First Nations Health Authority analyzed accreditation in First Nations health services in Canada. It investigated three accreditation bodies: Accreditation Canada, Canadian Accreditation Council, and Commission on Accreditation of Rehabilitation Facilities (CARF) International. This report highlighted several positive impacts of accreditation as well as challenges in implementing accreditation in Indigenous health organizations. The organizations investigated reported concerns with the accreditation process and the associated personnel's skill and approach. This included:

- Perceived punitive tone
- Inconsistencies in surveyor skill levels
- Inequities in assessment processes
- Organizational buy-in
- Poor communication
- Protected appeal processes
- Deficiencies in the resource database
- Challenges garnering enthusiasm from external partners, particularly community leadership, resulting in policy denials required for accreditation by chiefs and councils
- Lack of alignment between bands and accreditation standards, which can relate to the broader problem of "one-size-fits-all" approaches
- Difficult to scale the process from large to small organizations, with the result that feedback given to smaller organizations is often deemed irrelevant
- Capacity-related challenges, including staff and governance turnover, inadequate funding, training, and resources for client paperwork
- Burdensome time commitment, excessive paperwork, overall workload
- Accreditation process not reflective of organizational culture within the First Nation community context, lacking Indigenous lens and conflicting with local cultural protocols
- Redundancy and inconsistency in the accreditation process

Respondents also said that accreditation:

- Contributed to First Nations self-determination in health care, such as increased involvement from families in planning their own care
- Improved client safety in their organization
- Increased quality of care
- Led to improved health outcomes
- Increased credibility, staff buy-in, and sense of pride
- Contributed to the development of policies, processes, and procedures

Current State of Accreditation in the Six Priority Areas

The six priority areas included access to integrated youth services, integration of MHSUH in primary care settings, digital MHSUH apps, integrated services for people with complex needs - early psychosis intervention (EPI), substance use health treatment centres - withdrawal management and substance use health workforce competencies. Overall, there were no federal standards in any of the six priority areas. Research studies in the six priority areas are described below.

Children and Youth

Integrated Youth Services

International research studies related to Integrated Youth Services in Canada, Australia, the United Kingdom, and the United States found that accreditation was a critical success factor for youth mental health care as it ensured fidelity to the appropriate standard of care and enabled continuous quality improvement.[34] Key principles for accreditation of in integrated youth services were[34]:

- Prevention and early intervention
- Youth participation
- Respect and co-design
- Community engagement
- Education and consultation
- Reduced stigma and financial barriers
- Choice regarding options for access and treatment and care
- Family engagement and support
  Scientific evidence as a key guide

Research in the area of accreditation and its role in integrated youth services is limited. There is a need for more research in this area, particularly from the Canadian lens.

Primary Health Services Integration

Integration of MHSUH in Primary Care Settings

Studies have suggested that accreditation in primary care may increase the capacity for addressing MHSUH concerns.

- When primary care was accredited, there was an increased capacity to offer mental health services[35]
- Accreditation improved screening and treatment of behavioural health in primary care settings[36]
- When considering training for the primary care workforce in mental health, core competencies may differ based on academic accrediting bodies[37]

While there were no standards on integrating MHSUH and primary care, Health Standards Organization has released a standard on Integrated People-centred Health Systems, which applies to integrated care more generally.[38] Further studies have reported on qualitative and literature-based perspectives on the integration of MHSUH into primary care. A report from the Mental Health Commission of Canada and the Community Addictions Peer Support Association reported that 89% of survey respondents preferred integrated services due to their ability to secure the diversity and depth of expertise required for complex issues, coordinate and simplify logistics of care, and ensure concurrent issues were dealt with at the same time[40].**Error! Bookmark not defined.** The same survey found that respondents feared integrated services would lead to a cumbersome intake process, loss of specialization in treatment, and longer wait times if concerns were not “complex enough”[40] A scoping review from the Mental Health Commission of Canada and the Canadian Centre on Substance Use and Addiction found that strong leaders who can champion innovative models of integration into primary care facilitated integration.[39]

Digital MHSUH Apps

Studies on accreditation relating to digital MHSUH apps reported that accreditation led to improved trustworthiness of apps,[40] promoted client and public engagement with digital health,[41] and provided considerations for accreditation programs.[40] Moreover:

- Accreditation by respected clinical organizations was an important factor in promoting client and public engagement with digital health[41]
- More research was needed on whether digital health initiatives should be accredited, how this should be done, and legal and ethical implications[41]
- Accreditation provided users with assurance that apps were trustworthy for management and care of their health, providing security and credibility [40]
- Providers expressed feeling more comfortable with recommending health apps to client when those apps have been accredited[42]
- Design of the accreditation process should be based on consensus between experts in the field of technology, health professionals, clinicians, health communication professionals, expert patients, institutional representatives, and members of the public[40]

A review of clinician and consumer representative perspectives on accreditation in digital mental health interventions found that knowledge holders agreed that standards should be established for reporting program content and e-health trials, including adverse event reporting.[43]

People with Complex Needs

Integrated Services for People with Complex Needs - Early Psychosis Intervention (EPI)

While there are no national EPI standards, there are several provincial standards for EPI in Canada, specifically in Ontario,[44] BC,[45] Nova Scotia,[46] and Quebec.[47] These standards focused on[44,45,46,47].

- Facilitating care access
- Intake and early identification
- Comprehensive client assessments
- Treatment and care promotion
- Prevention and advocacy
- Psychosocial support for the client
- Family and community education and support
- Professional training and education
- Program structure and operations
- Quality improvement
- Client services
- Outpatient outreach services
- Speciality services

Literature suggested that revealing that while fidelity to standards facilitated program coherence, it also posed challenges. Specifically, adhering strictly to standards became a source of tension when attempting to tailor services to meet the unique and diverse needs of local communities. This indicates that a delicate balance is needed between maintaining standards and allowing flexibility for adaptation to local contexts within EPI program development[48].

Substance Use Treatment Centres - Withdrawal Management

Limited literature and evidence currently exists regarding the role of accreditation in substance use treatment centres and withdrawal management. Recognized as a growing concern with significant complexities, this priority area demands ongoing attention and research to address emerging challenges marked by intricate nuances.

The existing evidence on the impact of accreditation in substance use health presents a nuanced picture, encompassing both positive and challenging aspects. One study reported a positive effect, highlighting that accreditation reduced the risk of substance use in the treatment of substance use disorders[49]. Another study in the United States found that accreditation, coupled with the presence of staff physicians, influenced the adoption and availability of effective medications, contributing to enhanced substance use treatment[50, 51].

In contrast, a report from the Canadian Centre on Substance Use and Addiction underscored significant challenges associated with accrediting residential substance-use treatment centres in Canada[52]. The report identified accreditation as challenging for many organizations, particularly smaller ones grappling with budgetary and staffing constraints. In Canada, residential substance-use treatment services often operate without regulated accreditation, relying on a voluntary basis[52]**Error! Bookmark not defined.**. The absence of regulatory requirements or legislation raises concerns about the consistency and maintenance of current accreditation standards.

These diverse findings underscore the intricate landscape surrounding accreditation in substance use treatment centres and withdrawal management and the need for greater understanding of accreditations role and impacts.

Substance Use Workforce Competencies

Workforce competencies are intended to be used by certification and regulation bodies in conjunction with complementary standards and federal, provincial and territorial requirements.[53] They can be used by multiple professionals in the workplace to create job profiles, interview, evaluate job performance, and clarify succession planning requirements.[53] More research is needed on how to implement workforce competencies.

Engagement Insights

Engagement Activity Approach

To gain comprehensive insights into the accreditation process and its impact on MHSUH services across Canada, we employed a multifaceted engagement methodology. This approach included individual expert interviews, an online survey, and online small group discussions that engaged a diverse range of knowledge holders from the MHSUH fields.

These methodologies were meticulously designed to explore both the current state and future vision for accreditation in MHSUH services, leveraging the expertise of individuals with lived and living experience, clinicians, accreditation organizations, policy makers, and researchers. This comprehensive engagement strategy ensured a well-rounded understanding of the accreditation landscape, reflecting a wide array of experiences and visions for enhancing MHSUH services in Canada.

Specifically, a group of SCC Steering Committee members representing individuals with lived and living experience, clinicians, accreditation organizations, policy makers, and researchers participated in the co-design of all engagement materials including the survey questions, focus group sessions and interview guides. This step ensured that all committee members had the chance to review the materials and provide any feedback they wished to contribute before proceeding with the engagement activities.

SCC Steering Committee Demographics (n=56)

Category	Per cent
Experts, Academics, Researchers, and/or Academic and Research Bodies	26.8%
Industry, Providers, and Professional Associations	21.4%
Indigenous Partners	10.7%
Pan Canadian Health Organizations	10.7%
Standards Development Organization	10.7%
People with Lived and Living Expertise	8.9%
Government	8.9%
Mental Health and Substance Use Interested Parties	1.8%

Six Priority Areas

This project involved consulting experts, academics, clinicians and people with lived experience in the six identified priority areas: integrated youth services, mental health and substance use health (MHSUH) in primary care settings, digital MHSUH apps, integrated services for people with complex needs (early psychosis intervention - EPI), substance use health treatment centres (withdrawal management), and substance use health workforce competencies. Their insights were sought to understand their perspectives on accreditation, gather knowledge and insights related to the latest evidence and literature in their respective priority areas. Additionally, participants were asked to identify any additional connections to other key knowledge holders who should be involved in this work.

Thought Leader Interviews

To start the gathering of key insights, Exult led 14 confidential, in-depth interviews with thought leaders in the MHSUH fields across Canada. These interviews were strategically designed to provide a foundational overview of the prevailing issues, themes, and challenges within the sector, with a particular focus on the practical application of accreditation.

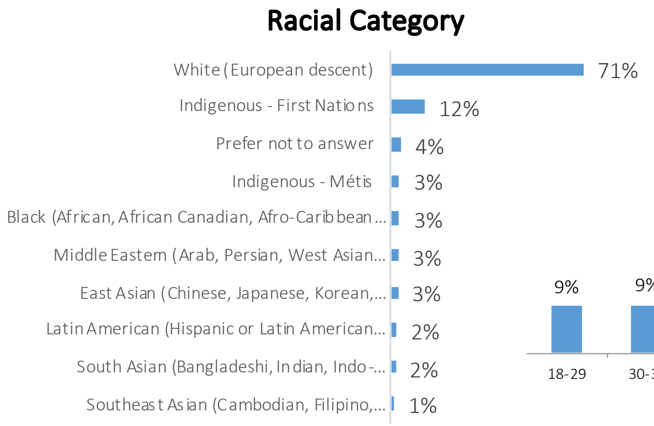
Respondents who regularly interact with accreditation processes in their professional capacities offered candid assessments of the current landscape and shared their visions for the future. They discussed the necessary advancements and strategies required to enhance the effectiveness and reach of accreditation in MHSUH services, thereby setting the stage for a deeper exploration of how to achieve these goals.

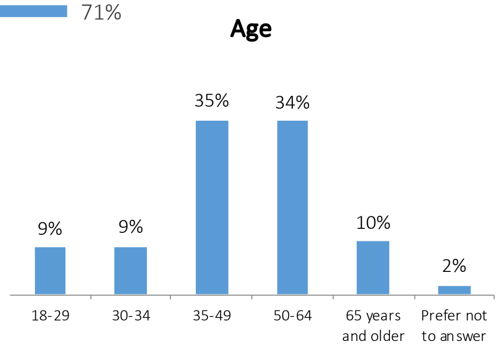
Survey

The engagement approach also included a 15-minute digital quantitative survey aimed at comprehensively understanding the experiences and perspectives of individuals involved in MHSUH work. The survey gathered responses from a diverse sample of 445 respondents, who were identified through networks of people directly engaged in the MHSUH sector.

The primary focus of the survey was to collect data to support our understanding of the current needs and opportunities for assessment programs, with an eye towards informing future improvements and initiatives in the MHSUH field. See below for a demographic breakdown of all survey respondents.

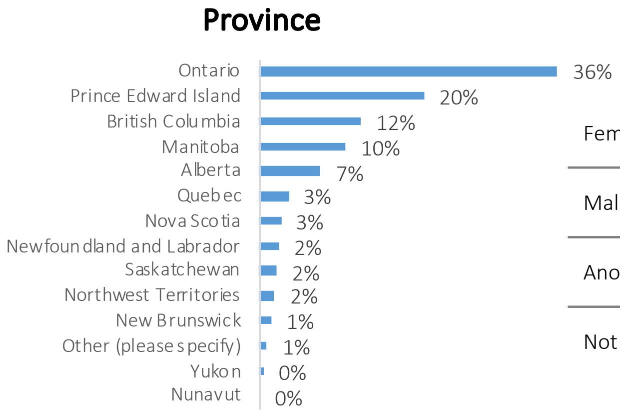
Survey Respondent Demographics (n=445)





Persons with Disability

Yes	13%
No	82%
Prefer not to answer	5%

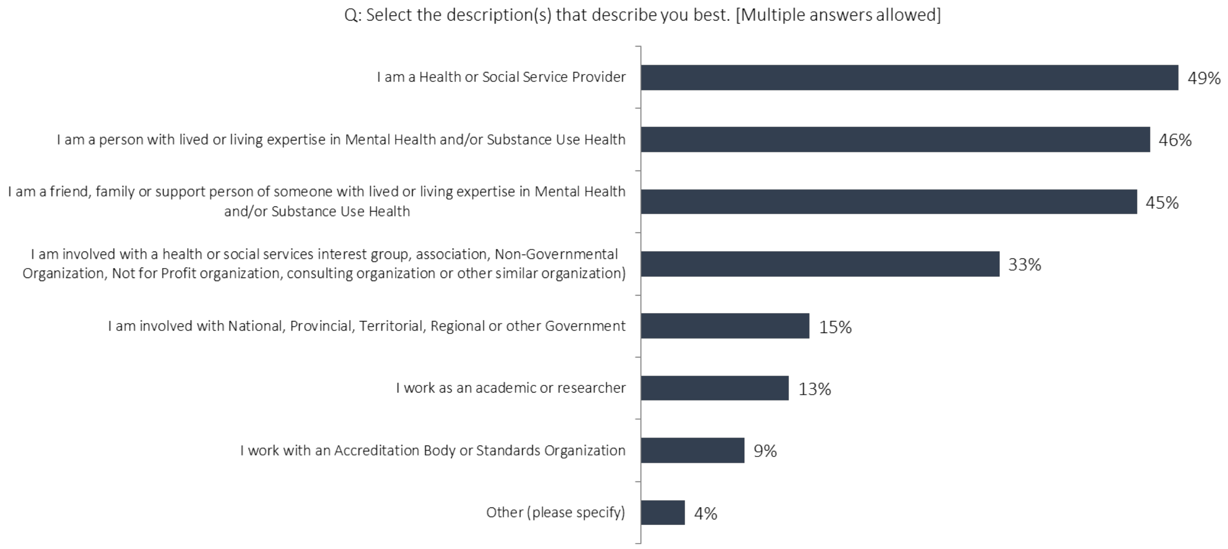


Gender

Female	74%
Male	22%
Another gender	2%
Not applicable	1%

On Reserve Profile

On a reserve	34%
Off reserve	66%


Q: Select the description(s) that describe you best. [Multiple answers allowed]

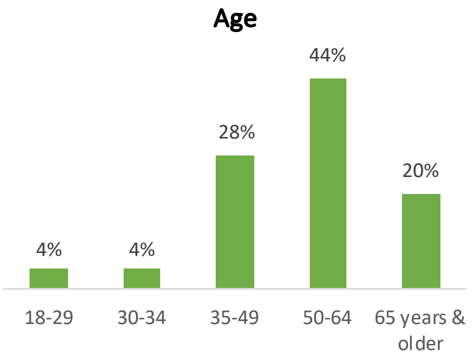
Small-group Discussions

Exult also led six in-depth small-group sessions with a total of 25 respondents from across Canada who are directly involved in the MHSUH sector. These sessions were designed with the goal of gaining a nuanced understanding of how accreditation currently impacts MHSUH services and identifying what is necessary to construct a more effective system in the future. Respondents representing a wide range of roles, demographics, and interests within the MHSUH field engaged in discussions that provided valuable insights into the real-world implications of accreditation practices and offered perspectives on future enhancements. See below for a demographic breakdown of participants in the small-group discussions.

Small Group Discussion Demographics (n=25)

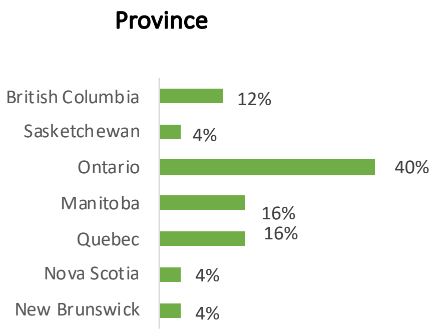
Gender

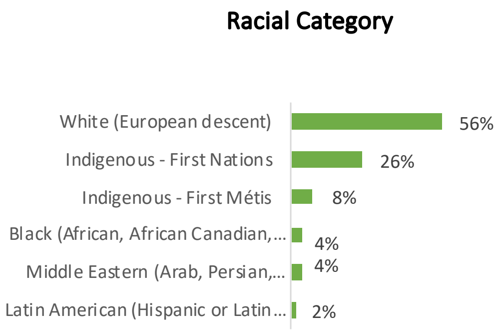
Female	76%
Male	20%
Another gender	4%



On Reserve Profile

On a reserve	29%
Off reserve	71%





Experience with Accreditation

Yes	68%
No	32%

Perceptions of MHSUH Care in Canada

Perceptions of MHSUH Care in Canada Today

To gain a comprehensive understanding of accreditation in MHSUH, it was critical to understand the current perceptions and experiences of how MHSUH care is delivered today. This exploration aimed to contextualize the recommendations in this report within the present-day landscape.

Based on the results from the survey, there is widespread dissatisfaction with the current state of MHSUH care in Canada, with dissatisfaction being most pronounced among health and social service interest group (77%) and least among National, Provincial, Territorial, Regional and other Government (48%). Overall, however, satisfaction was consistently low across all respondents for both mental health care and substance use health.

Satisfaction with Current State of Mental Health Care

Most Dissatisfied Most Satisfied	Satisfied	Neutral	Dissatisfied
Full Sample (n=326)	9%	21%	70%
Indigenous (n=67)	3%	30%	67%
I am a person with lived or living expertise in Mental Health and/or Substance Use Health (n=373)	9%	20%	71%
I am a friend, family or support person of someone with lived or living expertise in Mental Health and/or Substance Use Health (n=185)	6%	20%	74%
I am a Health or Social Service Provider (n=193)	10%	20%	70%
I work with an Accreditation Body or Standards Organization (n=35)	12%	34%	54%
I am involved with a health or social services interest group, association, Non-Governmental Organization, Not for Profit organization, consulting organization or other similar organization) (n=132)	6%	14%	80%
I work as an academic or researcher (n=53)	4%	23%	73%
I am involved with National, Provincial, Territorial, Regional or other Government (n=61)	21%	28%	51%

Satisfaction with Current State of Substance Use Health

Most Dissatisfied Most Satisfied	Satisfied	Neutral	Dissatisfied
Full Sample (n=398)	11%	22%	67%
Indigenous (n=67)	8%	22%	70%
I am a person with lived or living expertise in Mental Health and/or Substance Use Health (n=373)	10%	21%	69%
I am a friend, family or support person of someone with lived or living expertise in Mental Health and/or Substance Use Health (n=185)	9%	20%	71%
I am a Health or Social Service Provider (n=193)	12%	18%	70%
I work with an Accreditation Body or Standards Organization (n=35)	9%	34%	57%
I am involved with a health or social services interest group, association, Non-Governmental Organization, Not for Profit organization, consulting organization or other similar organization) (n=132)	7%	16%	77%
I work as an academic or researcher (n=53)	5%	21%	74%
I am involved with National, Provincial, Territorial, Regional or other Government (n=61)	22%	30%	48%

Despite a strong sense of dissatisfaction with MHSUH care today, there were suggestions for improvements. These included:

End the stigma around mental health and substance use

> *“From a consumer standpoint, if one compares the standard of care one receives for medical vs. psychiatric (for the sake of ease, I am adding SU care under the psych umbrella) care, the one significant difference is stigma. Clients are stigmatized and their care is stigmatized. People are afraid of people who use drugs and people who are mentally ill. The quality of care would be improved if people weren’t afraid, were provided with anti-stigma training, if people were adequately supported during training, and if people were provided with ongoing education throughout their professional career.”*

Critical gaps in MHSUH care need to be improved

> *“There are too many gaps when accessing health care and support for mental health and substance use. An example being incredibly long wait times. These issues are TIME SENSITIVE and require immediate action from service providers, community organizations and other services.”*

> *“Additionally, there has to be a standard of care like there is for medical diagnoses. The variability in care for people with MHSU concerns in emergency departments is staggering. The variability in prescribing practices for SU care is STAGGERING. Prescribers MUST be held accountable.”*

> *“For mental health services, there needs to be more funded therapeutic services, increased training and competency in suicide and risk assessments, increased Assertive Outreach Teams. For substance use, beyond consistent, national frameworks for training — there needs to be more services aimed at supporting people using crystal methamphetamines, we need 24/7 stabilization sites for people after overdose/significant substance or alcohol use to divert from emergency departments, consistent frameworks and understanding of harm reduction worker roles, funded alcohol/substance use case management and counselling across the spectrum of substance use i.e. harm reduction/low barrier/therapeutic treatment/residential treatment settings.”*

Better integration of mental health and substance use health care

> *“Integration of mental health and substance use health care is needed. We know that the mental health of youth (and adults) was negatively impacted during the pandemic, and we still haven't embedded mental health and substance use health fully into curriculum in schools. Urgent care is needed, as is prevention.”*

> *“There needs to be better collaboration between mental health and substance use services and better public education about how these services work.”*

Improved access to culturally safe care

> *“Currently, the access to culturally safe mental health care and substance-use Health care is a large issue that needs to be improved. There needs to be training to ensure cultural safe care exists within extended health benefit providers and health authorities. This includes requiring cultural safety curriculum for hands-on and clinical training (held in person, or virtual courses). Further, the access needs to be culturally safe for all populations. Within rural, remote, and Indigenous communities, access to care that is culturally safe is challenging resulting in individuals not opting for care until too late. Culturally safe care in the realm of mental health care and substance use health care should incorporate a person-centred approach that is trauma-informed and incorporating the unique cultural context of the person accessing care. Options need to be provided, allowing individuals to determine what their care looks like. This may look like for what their care would look like, what is on the wall in the space, where care is being accessed, who an individual can connect with (elder/knowledge keeper) or working with individuals who identify similar to them (e.g. a Métis individual accessing care working with a Métis provider).”*

Improvements to harm reduction programs

> *“There needs to be equal investment in harm reduction programs and services that incorporate approaches that centre the individual in their journey. Mental health and harm-reduction services should provide a wide breadth of support for individuals where they are at, communicating the outcomes that are available and allowing the opportunity for the individual to choose what services they would like to access. Record keeping of how individuals are accessing these different services and advocating for these services to be more accessible is needed. Evidence shows safe supply centres, overdose prevention sites, culturally safe resilience groups following a trauma-informed curriculum, counselling groups for residential school survivors are benefiting the community. Providing equitable and continuous funding and resources for organizations that support a specific population (such as Métis Nation British Columbia) should be created so known gaps within the system can be addressed sustainably by the community itself.”*

Enhanced training for health service providers

> “*Best Practice Educators and Clinical supports need enhancements; there are a lot of dedicated individuals working hard with what we have, but we need more training, more support, more collaboration; this is all potentially on the table, but not yet out to the workers and the clients.”*

Vision for the Future of MHSUH Care

The MHSUH space is broad and complicated and the gaps in the accreditation process are indicative of larger issues in health care across Canada, including lack of resources, inequitable access to treatment, inconsistent regulations and treatment pathways and staff shortages. Despite these complexities, respondents expressed a resilient sense of hope for the future of MHSUH care in Canada.

> *"This future envisions a compassionate, accessible, and culturally competent health care landscape where every individual feels empowered to seek help and mental health is championed as fundamental to overall health."*
>
> *"In envisioning the future of Mental Health and Substance Use Health care in Canada, I imagine a system that prioritizes **holistic and person-centred care**, acknowledging and addressing the underlying factors impacting individuals' well-being. Services would integrate with other health care disciplines, ensuring comprehensive support for both mental and physical health needs.*
>
> ***Accessibility** would be a cornerstone, reaching all Canadians regardless of location, socioeconomic status, or cultural background.*
>
> *A future with **reduced stigma** is crucial, achieved through public awareness/competency campaigns fostering understanding and support.*
>
> ***Prevention and early intervention** would be central, with a focus on mental health promotion and timely responses.*
>
> ***Cultural safety and health equity** would be ingrained in service delivery, particularly for Indigenous Peoples and other equity-deserving communities.*
>
> ***Communities** would actively participate in shaping programs, fostering empowerment and ownership of health care solutions.*
>
> ***Innovative technologies and data-driven approaches** would complement traditional care, and the well-being of health care professionals would be prioritized through support and training.*
>
> ***Collaboration** between governmental agencies, health care providers, and advocacy groups would be strengthened, ensuring a united effort in addressing complex challenges.*
>
> ***Trauma-informed care** would be the standard in creating safe environments for healing. Policy reforms and increased funding would underpin a resilient and responsive health care system, solidifying mental health as an integral part of overall well-being.*

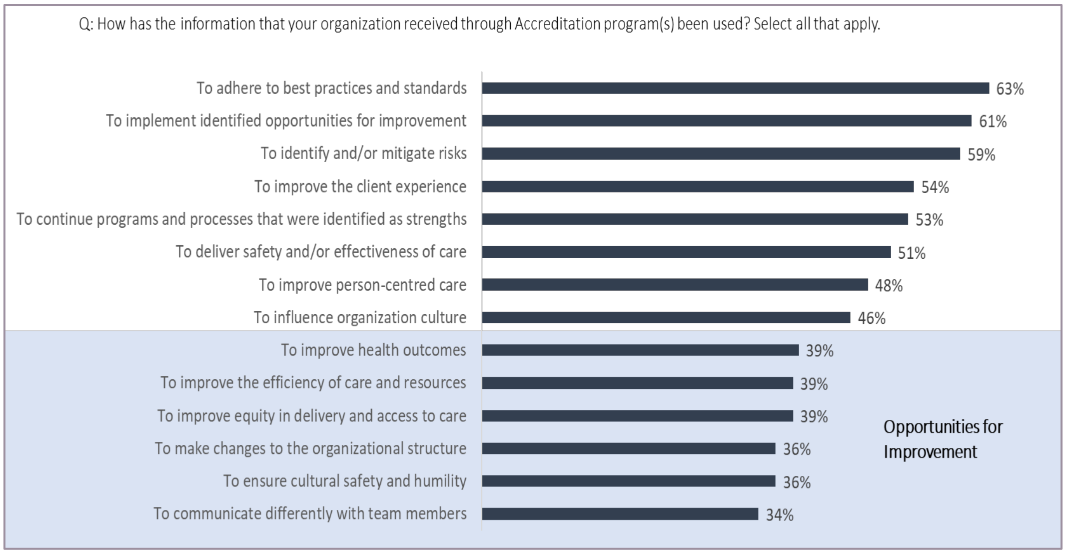
Knowledge and Use of MHSUH Standards and Accreditation

Knowledge and use of Standards and Accreditation

Throughout the engagement sessions it became clear that there is a general familiarity with MHSUH standards among various knowledge holders, with a recognition of their utility in guiding quality care. Based on survey results, 68% of the 341 respondents said that they are familiar with MHSUH Standards in Canada. Furthermore, 51% of respondents had experience with MHSUH Accreditation and were directly involved in the accreditation process.

Current Use of Accreditation Information

Respondents who were involved in accreditation at their organizations provided insights into how the information obtained through accreditation programs has been utilized. Largely, accreditation has been used to adhere to best practices and standards (63%), to implement identified opportunities for improvement (61%), to identify and mitigate risks (59%) and improve client experience (54%). Accreditation information was least used to improve health outcomes (39%), improve efficiency of care and resources (39%), improve delivery and access to care (39%), make changes to organization structures (36%), ensure cultural safety and humility (36%) and communication differently with team members (34%).



Selection of Accreditation Programs

When survey respondents were asked about the most important features of an accreditation program their key priorities included those that supported equity in the delivery of assessment programs (94%), cultural safety of standards (84%), and the accuracy of standards. Additionally, high importance was placed on human resources (79%), relevance/bias of standards (77%), capacity (77%), and time (77%). These results highlight the desire for accreditation programs that prioritize equity, cultural safety, and accuracy. They also underscore the importance of recognizing the complexity and resource-intensive nature of accreditation programs, emphasizing the need for accessibility to various organizations with differing capacities, time constraints, and human resources.

How important are the following factors when considering Accreditation Programs?

	Full Sample n=282
Equity in the delivery of assessment programs	94%
Cultural safety of Standards	84%
Accuracy of Standards	83%
Human Resources	79%
Relevance / Bias of Standards	77%
Capacity	77%
Time	77%
Surveyor Bias	76%
Funding	75%
Independence of accreditation programs	74%
Government Policies	69%
Organization Size	51%

Alignment with the Literature

The current body of evidence regarding knowledge and perceptions of accreditation within the health care sector, particularly among professionals and accreditation personnel, offers vital insights into the effectiveness and impact of these processes.

Health Care Professionals Perceptions of Accreditation

Overall, the evidence aligns with the findings from the engagements; it highlights that health care professionals at accredited organizations generally have a positive attitude towards accreditation[54,55,56,57,58].

Health care professionals said that:

- Accreditation led to improvements in client-centred care, quality of clinical records, organizational culture of units, improvement of patient safety culture, and perception of standardization of the clinical practice.[54]
- Accreditation was more likely to be successful when programs were collaborative, valid, and used relevant standards; were favorably received by health professionals; when health care organizations were ready to implement accreditation; and when accreditation was appropriately aligned with other regulatory initiatives and supported by relevant incentives[56]
- They support accreditation programs in aged care facilities[57]
- Accreditation enhanced client protection, through staff adherence to best practices, improved documentation, client handover practices, and incident reporting[55]

Accreditation Personnel Perceptions of Accreditation

Accreditation personnel, including surveyors, representatives from accreditation-seeking organizations, and accreditation body personnel said six factors influenced survey reliability:[59]

- The accreditation program, including documentation and surveyor accreditation reports
- Members’ relationship to the accrediting agency and survey team
- Accreditation agency personnel
- Surveyor workforce renewal
- Surveyor workforce management
- Survey team conduct, including coordinator role

People with Lived and Living Experience

To our knowledge, no studies have investigated the perspectives and views of people with lived and living experience on accreditation. This is a gap in the literature that we aimed to address in our primary research.

Health care professionals expressed an overall positive attitude towards accreditation and said that it led to improvements in client-centred care, quality, patient safety culture, standardization, and adherence to best practices.

Perceived Benefits of MHSUH Standards and Accreditation

Perceived Benefits of Standards and Accreditation

While satisfaction with the current state of MHSUH care is generally low, there were positive perceptions suggest that accreditation has the potential to enhance MHSUH care. According to survey results, areas with the highest perceived improvements through accreditation programs include the safety and effectiveness of care (86%), adherence to standards informed by best practices (82%), health outcomes (80%), and person-centred care (80%). Conversely, the lowest perceived improvements were observed in equity in delivery and access to care (75%), cultural safety and humility (71%), and efficiencies of care and resources (70%).

	Worsens	No Effect	Improves
Health outcomes	4%	16%	80%
Person-centered care	5%	15%	80%
Equity in delivery and access to care	2%	23%	75%
Safety and effectiveness of care	1%	13%	86%
Cultural safety and humility	2%	27%	71%
Efficiencies of care and resources	4%	26%	70%
Adherence to standards informed by best practices	2%	15%	82%

Thought leaders in this project conveyed a shared view that accreditation enjoys a commendable reputation and is highly esteemed among health and social service providers. Respondents unanimously recognize accreditation as pivotal, establishing guidelines for quality care, fostering continuous improvement, and enhancing organizational reputation. It is also seen as instrumental in standardization, addressing disparities in care delivery. Moreover, accreditation contributes to improving staff performance and is considered a benchmark for best practices, particularly within organizations that are dedicated to accreditation.

Enables Best Practices

- Accreditation provides guidelines for best practice, and encourages organizations to improve their services
- Regulations to ensure data security and consent for collection of data

Enables Improvement and Change

- Helps to identify operational strengths & weaknesses
- Improves operational efficiencies such as reducing wait times
- Improved document and SOPs
- Acts as a validation for insurance claims & procurement

Enhanced Quality and Safety

- Improves the quality of care
- Improved service increases client safety
- Reduces the risk of adverse events

Enhanced Credibility

- Provides a stamp of approval
- Sense of pride within the organization or community
- Increases perceptions of legitimacy and quality of the treatment program
- Elevates the profile of the organizations when they are applying for funding
- Makes it easier to attract donors

Employee Development

- Provides a way to measure performance of staff, and the outcomes of treatments
- Provides guidelines that help to train new staff
- Facilitates employee preparedness
- Aids workplace satisfaction

Improves Standardization

- Standardizes programs & services to reduce health disparities
- Improves standardization across delivery and access to programs & services
- Enables the effective implementation of MHSUH programs
- Access to a consistent source of national data on MHSUH

Overall, Accreditation in the MHSUH sector is held in high regard and valued for establishing a framework for quality care. It is recognized for instilling a culture of quality and engendering trust within organizations, and it often serves as a point of pride, acting as a seal of approval for care seekers. It is also seen as a catalyst for enhancing various aspects of service delivery and organizational functioning within the MHSUH sector.

Quotes on the Strengths and Benefits of Accreditation Programs

The key themes and findings related to the strengths of accreditation include:

Enables best practices: Accreditation promotes adherence to best practices, ensuring that organizations stay informed and implement the latest evidence-based standards.

"Accreditation helps with making organizations aware of new and emerging practices and how best to respond to needs based on these practices. Indirectly that should improve outcome and the client experience."

Enabling improvement and change: Accreditation identifies organizational strengths and weaknesses, guiding the development of standardized actions to address gaps and opportunities for improvement.

"It has focused the organization on what is important. And led to improving use of data to see who is not being served and design ways to reach underserved communities. It has also focused on areas where outcomes were poor and led to an investigation of the causes and possible solutions to improvement."

Improved quality and safety of care: Accreditation leads to enhanced care quality through the implementation of best practices, continuous improvement, and the use of data to identify opportunities for improving quality and safety.

"Accreditation has improved documents and standard operating procedures, but not overall health outcomes. While wait times have decreased, the number of individuals and types of presenting challenges have shifted where there are significant gaps in care."

Increased credibility: Accreditation status serves as a public indicator of quality, fostering organizational pride and legitimizing the quality of treatment programs.

"The fact that an external, independent organization has given their stamp of approval adds a layer of credibility. It's like having someone trusted vouch for the quality of the programs and services. Accreditation often involves a process of evaluation against established standards; this reassures me that the programs and services are meeting certain quality benchmarks and providing care that aligns with recognized standards. Seeking accreditation shows a commitment to quality care and indicates that the providers are not just doing the bare minimum but are actively striving to meet or exceed the best practices in mental health and substance use care."

Role of Accreditation in the Future of MHSUH Care

Accreditation can play a key role in addressing many of these future visions. The following table presents a comprehensive overview of the current challenges within the MHSUH system, accompanied by potential solutions and the envisioned impact on accreditation. This analysis underscores the critical role accreditation plays in driving positive changes and improvements within the MHSUH sector.

Current state	Potential Solutions	Impact on Accreditation
Crisis-based care: Often clients only seek or are given treatment when the situation is at its worst, which puts pressure on MHSUH agencies to find quick solutions with limited resources	**Circle care model:** Integrated holistic treatment to take the pressure off emergency care, reduce long wait times, include peer support, and create a more sustainable and fluid treatment pathway for clients	By focusing on sustainable care and seamless pathways for clients, accreditation becomes a driving force in transforming the existing crisis-based care paradigm leading to more client-centred, efficient, and responsive MHSUH system.

Treatment focus: Due to the high volume of MHSUH cases, agencies focus on immediate needs treatment, and families and care giver are left to manage continuum care	**Social focus:** On environmental issues that trigger treatment drop-offs like homelessness, lack of food security, unemployment, and long wait times for rehabilitation	By recognizing the importance of addressing environmental issues and supporting a holistic approach, accreditation standards can evolve to encompass the broader social determinants affecting treatment outcomes.
Siloed processes: Lack of integrated care makes the system challenging to navigate, creates barriers to care and slows down access to financial support	**Fluid pathway:** A clear and simple pathway for families and MHSUH agencies to navigate, with agencies that they trust and no delays in treatment	By recognizing the importance of collaboration, seamless transitions, and efficient navigation for families and agencies, accreditation becomes a catalyst for breaking down silos within the MHSUH system.
Inequitable access: Rural or Indigenous communities often travel long distances to access care, and community-based agencies don't have the resources to support clients in a holistic way	**Equitable access:** Staff who understand the cultural needs of the community and have the expertise to provide holistic care. Funds to build more treatment centres in rural areas.	By incorporating standards that emphasize cultural safety and health equity and the availability of services in underserved areas, accreditation becomes a driving force for reducing geographical disparities.
Criminalization: Punitive measures against MHSUH clients exasperates their issues and exposes them to more harm	**Decriminalization:** A focus on dealing with the source of criminal activity (person who sells drug, cannabis as a gateway drug, homelessness)	By incorporating standards that emphasize the importance of treating individuals with MHSUH concerns with dignity and compassion, accreditation can encourage a therapeutic rather than punitive approach.

Alignment with the Literature

Many of these perceived impacts align with findings from several studies that have investigated the impacts of Accreditation on health care organizations. Evidence from recent systematic reviews and primary research found that accreditation led to the following positive impacts:

- Positive impact on safety culture[60,61]
- Positive impact on process-related performance measures[60,61,62]
- Positive impact on efficiency[60,61,63]
- Positive impact on client length of stay[60]
- Positive impact on timeliness[61]
- Positive impact on client-centredness and quality of care[61,62,63,64]
- Strengthened competitiveness for funding opportunities[65,66,67]
- Positive impact on health status[63]
- Increased compliance with standards[68]
- Increased adherence to recommended guidelines[69]
- Enhanced structural and process elements[70]
- Sustained change[71]

In systematic reviews and primary research, accreditation led to a positive impact on health care organizations' safety culture, efficiency, effectiveness, timeliness, quality, client-centredness, health status, compliance with standards, and strengthened competitiveness for funding opportunities.

Perceived Limitations of MHSUH Standards and Accreditation

Perceive Limitations of Accreditation Programs

The results from the survey and discussions identified many perceived limitations of accreditation — shortcomings that can impact the effectiveness and credibility of the accreditation process. The challenges listed below underscore the necessity to increase supports to ensure accreditation processes are accessible, meaningful, and beneficial across the entire spectrum of MHSUH services.

Broader Input	Resource Intensive	Timeliness and Relevance of Standards	Sustained Accountability
• Standards should be informed by/done in collaboration with others • Standards are not designed with people with lived expertise, families and broader interest groups	• Requires an unrealistic amount of work for organizations • Too resource intensive • Leads to wasted time and resources • High cost of Accreditation • Limits funding opportunities • Not accessible to smaller less resources available settings	• Is difficult to execute in practice • Standards are constantly changing so hard to keep up with change • Can be too detailed and difficult to follow • Lack flexibility to a variety of different settings and resources	• Accountability is limited leading to superficial or time limited implementation of practices

Focus on Desired Outcomes	Cultural Competency and Equity	Regional Disparities	Credibility of Accreditation Surveyors
• Measures need to focus on outcomes and not just process • Technology, reporting and data quality needs to improve in order to establish the key links to desired outcomes • Community facilities want to have more inputs into the standards they are being evaluated against	• Does not support marginalized and underserved populations • Does not support equity-deserving populations • Does not embed indigenous lens and are culturally safe • Standards lack cultural competency	• Provincial policy leads to different regional perspectives and operating conditions impacting funding, expectations, and more • Each province controls their own system making it difficult to understand and work within the system	• Concerns that surveyor misinterpret during evaluation • Concerns of disconnect between Standard and actual care experiences • Concerns over surveyor expertise and impartiality

Key Themes on the Limitations of Accreditation Programs

Broader input: Standards can often lack broader inclusion, where clients and communities are adequately consulted, and their perspectives reflected in the standard development approach. This can ultimately lead to a disconnect between accreditation criteria and the real needs and cultural contexts of those served.

> “*To me, what is more important is the role of community engagement and dialogue and developing and implementing them. My vision for MHSU care in Canada is one that is driven by the needs and insights of communities: people accessing care, service providers, community organizations and local researchers and policymakers in dialogue to understand areas of unmet need.”*
>
> *“Oh, I think it’s pretty hard to create collaborative standards if all of the voices at the table that need to be there aren’t invited. And it’s pretty unusual for family caregivers to be invited. I don’t think that people who I see the families really providing the bulk of mental health care for a population that’s underserved. I don’t see them being invited to planning tables enough or opportunities to provide feedback about service needs being met or unmet.”*
>
> *“The difficulty is in agreeing … upon who should be setting standards, because who’s doing it, I think, is going to be defining the purpose. … Some of the areas that I think are seen as less academic and that are often more difficult to kind of measure and put into practice. I think those things get left out of traditional standards and especially mental health … those pieces are often some of the most impactful, the harder things to define that we do that actually make a really significant difference in the lives of our clients and the people that we work with and support.”*

Resources intensive: The process is seen as very resource-intensive and costly, making it difficult for organizations to justify the investment with a positive return on investment (ROI), thus limiting their funding opportunities and ability to meet mandated accreditation standards. Many organizations highlighted that this sets unrealistic amount of work for organizations to achieve. This is particularly true for smaller, rural, and particularly Indigenous organizations which often lack the necessary staff and financial resources to undergo the accreditation process.

> *“That is where the challenge lies. Our programs and staff are already spread too thin. We are motivated and excited to implement changes, but this adds a lot on the workload of already burnt-out staff.”*

> *“Coming from a community-based lens. I hear things like accreditation, and I hear paperwork, bureaucracy, time, capacity, resources, skills, things that the front line and folks who are in this neck-deep [lack] day after day. To me, it’s a huge chunk of time and things to invest. And unless there is accountability or some, unless it’s worth the investment, it gives me reason to pause just because I think accreditation takes a lot and standards are things that are hard to enforce.”*

Timeliness and relevancy of standards: The current challenge with having out-of-date standards in an accreditation program is that it fails to reflect the latest best practices and emerging needs, potentially compromising the quality and relevance of care provided.

> *“In terms of standards, yes, they are very valid and they’re very important to keep up, but they change all the time. They have to evolve. They have to be very fluid to move with the times because things are changing. Just in the substance use problem in the last year, it’s changed. And to go through an accreditation process, just to know that your information has been outdated by the time you finished, it’s tough to keep up.”*

> *“I’m of two minds when it comes to standards. On one hand, we want people to be treated well no matter where they go to participate in a program, we want people to have a standard of care that is HIGH QUALITY. BUT on the other hand, our current ‘best practices’ are still lacking. Look at numbers for relapses and persons overall ‘recovery/health and wellness’ after attending standard programs. So if we put in a standard and draw a hard line — we know the standards are already NOT enough to actually increase a person’s outcome after care (say five years after attending program), who would rate their substance abuse challenges and mental health as better than before attending program? I’m resistant to ‘standards’ unless we can prove these imposed standards actually work. Does providing x, y, z result in the desired outcome for the person and their community years down the road? If not, then we need to change how we are doing things. We need to ‘know/understand’ the core problem better.”*

Sustained accountability: The key concerns include the need for regular auditing to verify adherence to standards and the regular reviews to ensure practices in accordance continue to remain sustained. Organizations often revert to their usual operations post-accreditation missing the opportunity to fully implement and maintain changes that could lead to better service delivery and patient safety. This cycle undermines the potential benefits of accreditation, casting it as more of a periodic exercise rather than a genuine commitment to continuous and sustained change and even enhanced impact.

> *“We create these wonderful standards, but where’s the accountability? Because these standards are followed by a lot of wonderful providers, and a lot of providers absolutely don’t [follow them] and cause great harm in wonderful facilities, and there’s zero accountability.”*

> *“Standards can be helpful in improving mental health and substance use health care if the standards ensure accountability. Governing bodies for mental health professionals are needed within the provinces and Canada to ensure standards are followed, reviewed, implemented, and evaluated. Given that standards are culturally safe, trauma-informed, and person-centred, these can be meaningful to guide providers of how to promote a safer system. When there is no governing body to ensure accountability, investigation of providers who are not following standards [that are] outlined, the standards remain superficial guidelines and do not create change. There needs to be a governing body, way for participants to report when harm is done against the standards of practice and opportunity for formal investigations to be done.”*

> *“For example, the health authority, I know that they brought certain things up to standard for accreditation, and then once the process was over, things fell back into, let’s say, not being as good as they really ought to be. And then I didn’t see any possibility for people to intervene at that point and say, wait a minute, you guys got accredited for this, but you’re not doing it. It’s been ticked off.”*

> *“Our organization, at the time, rushed to ensure all standards were met when we knew accreditors were coming, but after the process was completed, went back to business as usual. So, it wasn’t often we had gaps identified. But, when we did, the expectation was to fix things, though follow-up throughout the rest of the year to ensure the change was maintained did not happen.”*

Focus on desired outcomes: Respondents conveyed a prevailing sentiment that accreditation, while acknowledged as important and beneficial in various aspects, often instigates only superficial changes. Critically, there is a perceived gap in focusing on outcomes that truly matter to clients and the broader community.

> *“Accreditation would mean the program/service meets a basic level of quality. It would marginally increase my trust in them, but to a limited degree. Just because a service is accredited does not mean that my experience in using that service will be good.”*

> *“Accreditation has improved documents and standard operating procedures, but not overall health outcomes. While wait times have decreased, the number of individuals and types of presenting challenges have shifted where there are significant gaps in care.”*

> *“If there were regular check-ins and reviews of the aspects of the programs that needed to be improved and the suggestions were implemented, tracked and assessed, I think that it could have a direct impact on health outcomes.”*

Cultural safety and equity: Standards, while aiming for inclusivity, often fall short in adequately incorporating and respecting cultural, religious, or racial practices and beliefs. There is a fear that nationally imposed standards might be applied too rigidly, potentially alienating the very clients they aim to serve.

> *“My perspective is that accreditation can be incredibly useful, but also incredibly limiting for people living in reserve who have very limited access to resources.”*

> *"Culturally safe care done by collaborating with individuals with lived and living experiences and communities that have been impacted by the ongoing harms of the system.”*

> *“I have been a clinical chief of psychiatry at multiple hospitals and been directly part of the accreditation processes looking at all the ROPs and indicators. The "equitable" word currently misses the main inequity that I have experienced which is the inequity in care for MHSU vs physical health care services.”*

Regional disparities and policy influences: There is apprehension about the practical application of these standards and the potential for increased bureaucracy, which could detract from frontline services. Respondents highlighted a need for transparency, continuous monitoring, and trust-building in the accreditation process.

> *“At the end of the day, when you're arguing over if the government says you need to be accredited, I'd be screwed for providing services. I live in the north. I would have families so disconnected because, oh, the local programs not accredited, we’ve got to send them down Toronto or somewhere else. And so what type of a disconnect is that? How is that a connection to community…appreciate the accreditation lens has to consider availability of options. And then let's talk about capacity…when you talk about accreditation within the First nations community, it's not even logical when you're outsourcing things like band managers. When you're outsourcing locums to come and provide services…is there any way that they have the manpower or the capacity to even visit an accreditation process? Absolutely not.”*

> *“Theoretically, as a researcher, I want to say that it would increase my trust in them. As a person with lived experience, though, I know that many of the services I have accessed and had terrible experiences with or seen others in my community have terrible experiences with are, in theory, not "supposed" to be that way. I think there's a sense among many people with lived experience of a huge gap in what is policy/law/standard/etc. ("the care we are told we can expect") and the reality of accessing care. I don't think it would actually increase my trust at all - I would assume no change until I experienced a real change firsthand.”*

Credibility of accreditation surveyors: Concerns regarding accreditation surveyors centre on misinterpretations during evaluations, potentially due to informal settings and misunderstandings of comments, as well as a disconnect between official standards and actual care experiences that undermines trust. The credibility of the process is heavily dependent on the surveyors' expertise, use of evidence-based criteria, and impartiality.

> *“During the approval evaluation period, the deficiencies noted were misinterpreted by the person evaluating. On the one hand this person questioned us in an informal setting (without informing us that it was official), and on the other hand she took literally certain things that had been said as a joke. These points were therefore not relevant, and we did not need help to correct them.”*

Alignment with the Literature

Several studies have reported on barriers and facilitators to accreditation and align with the findings described by respondents in this report. A detailed list of identified barriers and facilitators are listed here.

Organization-level barriers-level, included:

- Costs associated with accreditation and resource constraints[72,73,74]
    - For example, leadership said there were no additional financial resources allocated by the organization to fund accreditation efforts[75]
- Organizational resistance to accreditation[73,76]
- Organizational policies and culture[74]

System-level barriers included:

- Lack of financial resources[76,57]
- Lack of external incentives or pressures[74]
- Lack of tangible benefits of accreditation[72]
- Ensuring that standards are current and relevant[77]
- Survey processes and surveyor expertise[77,57]

Personnel-level barriers included:

- Lack of time[72,73,78]
- Resistance from clients[76,57]
- Lack of workforce skillset, education, and training on accreditation[72,76]
- Lack of workforce capacity[72,78,57,79]

In contrast, facilitating factors included:

- Having additional funding[73]
- Dedicated training and support for staff[72,76,73,55,79]
- Strong organizational culture and leadership[72,76,74]
- External pressure from legislation[74]
- Organizational buy-in, organization and workforce belief in accreditation[80]
- Alignment of accreditation with organizational beliefs, context, and model of service delivery[80]
- Administrative support, staff training, and expansion in application of electronic systems[55,79]
- Increased number of personnel[55]
- Improving client awareness about accreditation[55]

A 2021 study commissioned by the International Society for Quality in Health Care External Evaluation Association[13] investigated 53 organizations delivering 25 health care accreditation programs, 13 of which were mandatory[77]. This study found that accreditation programs ranged from being specific to programs, segments of organizations, and individual services to acute care in hospital or primary health care organizations. Programs used accreditation to review and promote quality and safety standards and improvements in health care organizations and services. The challenges these accreditation organizations faced included ensuring currency of standards, survey processes, surveyor expertise, and reporting mechanisms[77].

Recommendations for the Future of Accreditation

Recommendations

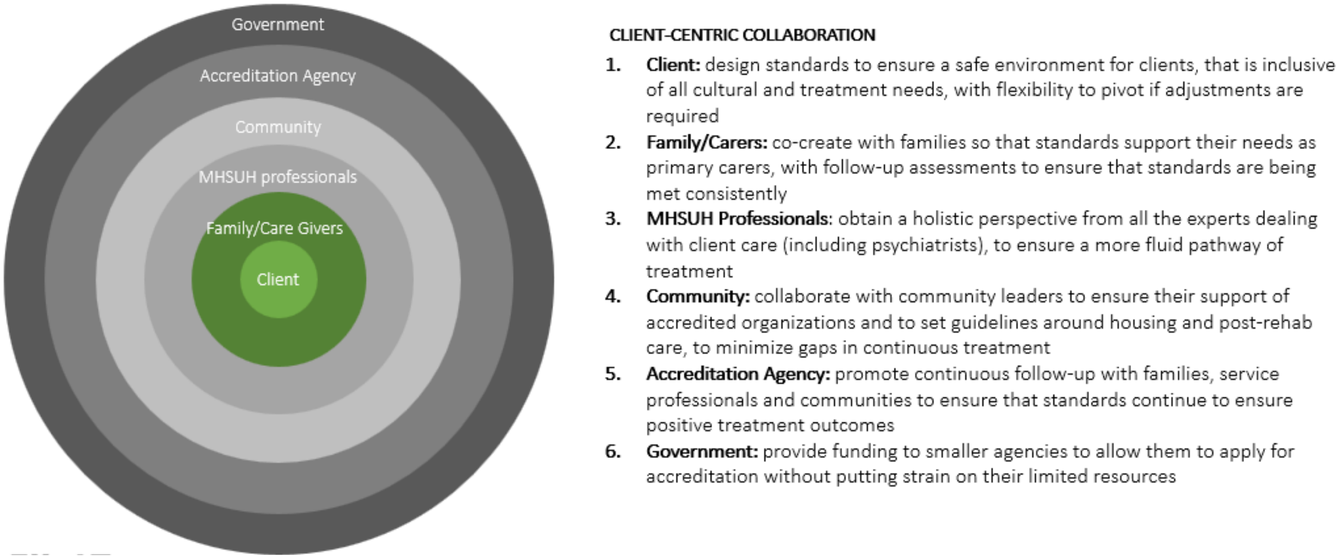
The recommendations below aim to succinctly summarize the insights we heard from various knowledge holders about accreditation, standards, and standardization in the MHSUH space and address the limitations of accreditation that arose in this report.

Recommendation 1: Importance of Client-Centric Collaboration

Based on the insights gathered, client-centred collaboration emerges as a critical component in enhancing the effectiveness and credibility of accreditation processes within MHSUH services. This approach prioritizes the needs, experiences, and perspectives of those receiving care, ensuring that accreditation standards and evaluations are not just procedural but genuinely reflect and respond to client needs. Client-centred collaboration involves engaging with clients as active participants in their care, acknowledging their unique cultural, economic, and personal contexts.

Because research shows that most people involved in MHSUH care are dissatisfied with the current state, accreditation agencies need to play more of an advocacy role in evolving and transforming to a more satisfactory system of care with more positive client outcomes and better employee satisfaction. Furthermore, there is a concern among agencies that nationally introduced standards might be enforced in a rigid or uniform manner, potentially alienating the very clients these standards are designed to assist.

This focus on client-centred collaboration helps bridge the gap between official standards and the actual care experience, fostering a more inclusive, equitable, and effective service delivery model that respects and responds to the diversity of client backgrounds and experiences.



CLIENT-CENTRIC COLLABORATION

1. **Client:** design standards to ensure a safe environment for clients, that is inclusive of all cultural and treatment needs, with flexibility to pivot if adjustments are required
2. **Family/Carers:** co-create with families so that standards support their needs as primary carers, with follow-up assessments to ensure that standards are being met consistently
3. **MHSUH Professionals**: obtain a holistic perspective from all the experts dealing with client care (including psychiatrists), to ensure a more fluid pathway of treatment
4. **Community:** collaborate with community leaders to ensure their support of accredited organizations and to set guidelines around housing and post-rehab care, to minimize gaps in continuous treatment
5. **Accreditation Agency:** promote continuous follow-up with families, service professionals and communities to ensure that standards continue to ensure positive treatment outcomes
6. **Government:** provide funding to smaller agencies to allow them to apply for accreditation without putting strain on their limited resources

Recommendation 2: Maintaining Timely and Relevant Standards and Accreditation Programs

During the engagement, when discussing standards many individuals highlighted the need to prioritize the development of national standards that are timely and reflect the current evidence and experience. Concerns were raised on outdated standards in accreditation programs, implement a systematic and regular review process for standards, involving diverse knowledge holders. This was further highlighted with variability in standards across different provinces and territories. It is recommended to establish a dynamic approach that allows for timely updates, incorporating real-world insights and data-driven assessments.

Additionally, promote transparency by actively sharing updates with accredited organizations, ensuring they are aware of changes and can align their practices with the latest best standards. This will enhance the quality and relevance of care provided while fostering a collaborative and informed health care environment.

Recommendation 3: Cultural Safety and Sensitivity of Standards and Accreditation Programs

It is important to ensure safety is woven through surveyors competencies and within standards and accreditation programs to better uphold principles of self-determination, equity, diversity and inclusion. The programs should be considerate of cultural, religious, or racial practices and beliefs. Standards and accreditation programs should be built in partnership with First Nations, Inuit and Métis people to ensure they reflect the practices, priorities, and beliefs across the many diverse communities and include content that promotes anti-racist and culturally safe practices. Surveyors should reflect the diversity of the population served including First Nations, Inuit and Métis surveyors. Ongoing collaboration with community leaders and organizations representing diverse populations can further inform the development and refinement of standards, ensuring they reflect the lived experiences of those accessing MHSUH services. By prioritizing cultural safety and health equity in standards and accreditation programs, it can support a more equitable and inclusive MHSUH system.

Recommendation 4: Optimized Accreditation Process

An optimal accreditation framework should be clear and straightforward, ensuring easy comprehension of the requirements by all stakeholders. However, it is imperative to recognize that accreditation is not merely a one-time event; it requires regular follow-ups and must be adaptable to changing circumstances. Ongoing assessments contribute to the flexibility and relevance of the accreditation framework over time.

Additionally, continual education is essential for all individuals engaged in the accreditation process. Comprehensive training for existing staff and providing accessible reference materials is needed to guide them through the process. A focus on ongoing education ensures that new staff members seamlessly integrate into the accreditation requirements, fostering a culture of understanding and compliance.

① Education

- Provide clear and simple application instructions, without acronyms or academic language
- Provide upfront training to explain the process and benefits, to ensure support from the whole team

② Collaboration and Co-creation

- Allow collaboration and co-creation from all stakeholders in client care, to ensure that standards are applied appropriately, and meet client needs
- This will also increase the sense of trust and pride in accreditation

③ Funding and resources

- Provide access to funding for smaller or rural agencies, so that accreditation does not put extra strain on their resources
- Provide a clear outline for how funding should be allocated

④ Deliverables

- Mandatory standards, consistently implemented across agencies
- A reference manual of guidelines and standards
- On-going training opportunities to maintain standards

⑤ Reporting and Accountability

- Ensure that standards are maintained through rigorous auditing and reporting
- Ensure that agencies who are not compliant face consequences like loss of their accreditation

⑥ Optimization

- Provide opportunities for on-going feedback, especially from care givers
- Regularly review guidelines to keep up with changes in MHSUH
- Work towards a fluid holistic treatment pathway across agencies

Recommendation 5: Increase Knowledge and Understanding of Standards and Accreditation

While “conformity assessment” may be a useful term in other disciplines, it did not have resonance within the MHSUH community engaged in this project and in most cases, leads to confusion. On the other hand, “accreditation” was more widely understood among the MHSUH community. However, despite its recognition, there exists a significant misunderstanding regarding what accreditation entails and what can be achieved through it.

In light of this, there is a need for concerted efforts to enhance the broader community's knowledge and understanding of accreditation. Effective communication should focus on highlighting the strengths of accreditation in a manner that is easily comprehensible for all key individuals involved. Quality accreditation programs have proven to yield various benefits, including operational efficiencies, enhanced care quality, facilitation of change, and the development of competent and prepared staff. Clear communication is pivotal to dispel misconceptions and ensure a more accurate understanding of accreditation and its potential contributions.

Moreover, there is a need for increased national attention to standards and accreditation to promote shared practices and reduce variability in standards and requirements depending on the accrediting body. It was clear through the engagement that there are many different interpretations and understandings of what standards are and what role they play in quality and patient safety. This may involve establishing a national standards and accreditation framework or strategy that sets expectations for consistent, high-quality standards and expectations for MHSUH services across Canada.

Recommendation 6: Accreditation as a Lever for Building a Culture of Quality and Safety

To enhance the impact of accreditation, we recommend ensuring accreditation is focused as a strategic tool for fostering a culture of quality and safety within MHSUH services. This involves not just ensuring adherence to best practices and high-quality care but also establishing a robust system for consistent data collection. This data should focus on tangible outcomes and impacts, serving as a reliable measure of accreditation effectiveness.

Accreditation agencies should play a crucial role in agreeing upon and collecting specific information on client outcomes. The standardized data collected can be reported and acted upon more efficiently, departing from current siloed and fragmented methods. This dual-purpose data serves to pinpoint areas of strength and improvement while providing a metric for staff and agencies to objectively evaluate their performance.

Recommendation 7: Focus on Integrated Care in Standards and Accreditation Programs

Many health leaders in the MHSUH field emphasize the importance of sharing standards and accreditation principles beyond the MHSUH discipline. Recognizing that mental health challenges span the entire care pathway, extending these standards to other health disciplines can expedite the identification, access, and support for MHSUH care by a wider range of health care professionals. This collaborative approach is designed to improve client outcomes and seamlessly integrate mental health services into broader health care contexts.

Additionally, consider accrediting networks of providers rather than individual organizations. By accrediting networks that embrace integrated models of care, there is an opportunity to foster a collaborative and interconnected approach to health care delivery. This approach aligns with the goal of promoting integrated care and improving the overall effectiveness and efficiency of mental health services across diverse health care settings.

Recommendation 8: Reducing Barriers to Implementing Accreditation Programs

To ensure accreditation is accessible to all organizations, regardless of size or resources, it is essential to address barriers, especially for smaller and resource-limited entities. Targeted assistance programs and capacity-building initiatives tailored to their unique needs can alleviate challenges. Furthermore, financial and resource support are needed to foster an inclusive accreditation landscape.

Exploring alternative accreditation models is also a viable solution. Accreditation is considered a “standards of excellence” approach when many believe that a “minimum standards” approach may be beneficial for some of the organizations that struggle to participate in accreditation programs. In order to work, these minimum standards would need to be devised in collaboration with communities and be administered predominantly by self-assessment or local peer review. This would allow for more elements of culturally safe care to be included.

Definitions

Definitions

Below is a list of terms and definitions that are used throughout this report:

Accessibility: Timely and equitable health care.

Accreditation (Health Service Provider Accreditation)**:** Related to health service providers, accreditation refers to formal, independent, third-party assessment conducted by expert peer surveyors against quality standards. Accreditation bodies such as CARF, Accreditation Canada, Canadian Accreditation Council, and Canadian Centre for Accreditation, conduct accreditation of organizations, systems, programs, and services, to ensure they meet the requirements of quality standards. Health and social service organizations leverage accreditation to be recognized for their commitment to a continuous process of improving the quality of their services and meeting standards of quality.

The definition of health service provider accreditation is comparable to “conformity assessment plus continuous quality improvement.” Both determine whether a program, service, organization, or system meets the requirements of a particular standard. The health service provider definition of accreditation additionally involves continuous quality improvement, such as surveyors providing suggestions for how to improve the program, service, organization, or system.

It is important to note that throughout this report we refer to the health service provider definition of accreditation, which can be interpreted to mean "conformity assessment plus continuous quality improvement.”

Accreditation: Accreditation refers to formal, third-party recognition that an organization is competent to perform specific tasks – namely, the work for which it is accredited.[1] It can be voluntary or mandated by government. It is a continuous quality improvement process to demonstrate that internationally and / or nationally prescribed standards have been met. The Standards Council of Canada is Canada’s national accreditation body. SCC accredits conformity assessment bodies, such as testing laboratories and product certification bodies, to internationally recognized standards.

Client: Preferred terms for describing people experiencing mental health problems are constantly evolving. We recognize that these distinctions can be highly personal and underlie the assumptions underlying an individual’s relationship with their care provider. With this in mind, we use the term “client” to refer to a person who receives, participates in, and benefits from health care. For this standard’s purposes, this term includes people seeking care for their mental health symptoms, substance use symptoms, or both. Depending on the care setting or context, a client may be referred to as a client, resident, or community member. When the organization does not provide services directly to individuals, client refers to the community or population that is served by the organization.

Client-centred care: An approach based on the philosophy of people-centred care which ensures that the client is a partner and active participant in their care and that the client’s goals, abilities, and preferences drive decision-making for care.

Conformity assessment: Conformity assessment is the practice of determining whether a product, service, or system meets the requirements of a particular standard.

Continuity of care/services: The coordinated, uninterrupted, and seamless provision of health care services throughout the client’s transition to other psychiatric services as they age or their needs change.

Cultural safety: An outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health system. It results in an environment free of racism and discrimination, where people feel “safe” when receiving and providing care and interacting with the health system.[1] A culturally safe environment is one that is physically, socially, emotionally, and spiritually safe and is free of challenge, ignorance, or denial of a person’s identity.[1]

Practicing cultural safety requires having knowledge of the colonial, sociopolitical, and historical events that trigger health disparities and perpetuate and maintain ongoing racism and unequal treatment.[1]

Designated support person (DSP): A person or persons chosen by a client to participate in the client's care. A client has the right to include or not include a designated support person in any aspect of the client's care. A client also has the right to change their designated support person(s) at any time, therefore the designated support person(s) may be different individuals at different points in the client's journey. Depending on the jurisdiction, a designated support person may be referred to by other terms, such as "essential care partner" or "essential family caregiver." Designated support person(s) is the preferred term to refer to the role of a support person for a client, which could include members of a client's family, friends, caregivers, loved ones, etc.

Evidence-based practice: A way of providing health care that is guided by a thoughtful integration of the best available scientific knowledge with clinical expertise. This approach allows practitioners to critically assess research data, clinical guidelines, and other information resources to correctly identify the clinical problem, apply the most high-quality intervention, and re-evaluate the outcome for future improvement.[1]

Effective: Providing evidence-based health care services to those who need them (WHO, 2024).

Health equity: Health equity is the absence of unjust, avoidable differences in health care access, quality, or outcomes. Measuring health inequalities allows us to identify differences that can be acted on and can be used to measure progress toward achieving health equity.[1]

Indicator: The Canadian Institute of Health Information definition states that: "Health indicators are summary measures designed to provide comparable and actionable information about priority topics related to population health or health system performance."[1]

Integrated care: Integrated care, also known as coordinated or comprehensive care, is a coordinated approach to health and care services that bring together providers from different disciplines and professional specialties to collaborate on an individual client's care for a sustained, repeated, or long-term period, rather than a single occurrence.

Learning health system: A learning health system is a health system in which data and experience are systematically integrated with evidence, such as research and best practices, and all knowledge is put directly into practice within the health system.

Mental health and substance use health services: A range of care and support services offered by dedicated mental health teams and substance-use health teams for mental health symptoms or substance use, behavioural addictions, or a combination. These services reflect a client-centred and integrated approach to the delivery of care, where health and social service providers collaborate to deliver timely and effective care and support services across care settings.

Organizational leaders: People in an organization who work in a formal or informal leadership capacity to support, manage, and recognize their team, unit, organization, or system (Dickson and Tholl, 2014). Leaders include executives and other senior leaders. For the purposes of this standard, an organization's governing body is not included in the term leaders or organizational leaders.

Peer support: A report prepared for the Mental Health Commission of Canada defines peer support as "any organized support provided by and for people with mental health problems or illnesses. The families of people with mental health problems or illnesses also provide peer support to each other." Related terms include "self-help," "mutual aid," "co-counselling" or "mutual support."[1]

People-centred: Providing care that responds to individual preferences, needs, and values, within health services that are organized around the needs of people.

Quality health care: Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with evidence-based professional knowledge.[1]

Recovery-oriented practice: The goal of a recovery-oriented practice is to support the client in gaining a meaningful and satisfactory life by promoting hope, attaining personal goals, social inclusion, and supportive relationships. A recovery-oriented practice aims beyond stabilization and symptom relief and is based on values and principles of person orientation and person involvement. Such practices respond to the diverse needs of clients across the lifespan. A recovery-oriented practice requires an active, dynamic partnership between a client and those involved in their care. The range of recovery-oriented practice options includes individual, family, or group counselling and therapy, medication, assisted therapy, detoxification, structured programs, and harm reduction approaches.

Safe: Avoids harm to the people for whom care is intended.[81]

Standardization: SCC defines standardization as the development and application of standards. This includes:

- The work of committees that develop standards
- The publication of standards by Standards Development Organizations
- The recognition of standards by national standards bodies such as SCC
- The application of standards by businesses, suppliers, and customers
- The verification that products or services conform to applicable standards (conformity assessment)
- The accreditation of organizations that provide conformity assessment services
- The use of standards and conformity assessment as an element in public policy as well as in international trade

Standards: A standard is a document that provides a set of agreed-upon rules, guidelines or characteristics for activities or their results[6].**Error! Bookmark not defined.** They can be voluntary or mandatory, and are distinct from Acts, regulations and codes, although standards can be referenced in those legal instruments[6]. High quality standards are people-centred, evidence-based, relevant, and responsive to current and future needs[7]. Standards help answer the question: “What is the best way to do this?” and their impact is indicated by widespread adoption and use.

Strengths-based approach: Strengths-based approaches are focused on the strengths or existing assets an individual has, as opposed to their deficits. Strengths can include personal strengths and self-determination, as well as their social and community networks, and other resources and opportunities for resiliency within reach of the individual.

Substitute decision-maker: A person or persons who have legal authority to make a care decision for clients who are incapable of making the decision for themselves. Depending on the jurisdiction, a substitute decision-maker may be referred to by other terms, such as “health care representative,” “agent,” “proxy,” “personal guardian,” “committee of the person,” “temporary decision-maker,” or “attorney for personal care.”

Team: People collaborating to meet the goals, needs, and preferences of the client. The team includes the client and, if incapable, their substitute decision-maker; designated support person(s) with consent; and workforce members involved in the client’s care. Depending on the care provided, the team may also include organizational leaders, volunteers, learners, external service providers, and visitors.

Trauma-informed care: An approach to care that recognizes that everyone has experienced psychological or emotional trauma, the lasting effects of which may influence their physical and mental health, behaviour, and engagement with health service providers and services. Trauma-informed care makes people feel safe and comfortable and avoids retraumatizing them.[1]

Workforce: Everyone working in or on behalf of an organization on one or more teams. The workforce includes those who are salaried and paid hourly, in term or contract positions, clinical and non-clinical roles, regulated and non-regulated health care professionals, and all support personnel who are involved in delivering services in the organization.

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Annex H

Glossary of Acronyms and Abbreviations

ACRONYM	DESCRIPTION
2SLGBTQIA+	Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and additional sexual orientations and gender identities
ADL	Activities of Daily Living
BHA	Black Health Alliance
BIPOC	Black, Indigenous, and People of Color
CAMH	Centre for Addiction and Mental Health
CAPSA	Community Addictions Peer Support Association
CCSA	Canadian Centre on Substance use and Addiction
CEO	Chief Executive Officer
CHEO	Children's Hospital of Eastern Ontario
CIHI	Canadian Institute for Health Information
CIHR	Canadian Institutes of Health Research
FNHA	First Nations Health Authority
FNIM	First Nations, Inuit, and Métis
GAT	Government Advisory Table
H&K	Hill & Knowlton
HC	Health Canada
HSO	Health Standards Organization
ITK	Inuit Tapiriit Kanatami
MHCC	Mental Health Commission of Canada
MHSUH	Mental Health and Substance Use Health
MNC	Métis National Council
NCCIH	National Collaborating Centre for Indigenous Health
NGO	Non-Governmental Organization
NSC	National Standard of Canada
PAS	Publicly Available Specification
PHAC	Public Health Agency of Canada
PWLLE	People of Lived and Living Expertise
SC	Steering committee
SCC	Standards Council of Canada
SDH	Social Determinants of Health
SDO	Standards Development Organization
TG	Task Group
TS	Technical Specification
WA	Workshop Agreement
WG	Working Group
WHO	World Health Organization

Annex I

Overview of Standards Development Organizations and other Entities Operating in the MHSUH Space

SDO Name	Description
The Spanish Association for Standardization and Certification (AENOR)	The Spanish Association for Standardization, UNE, develops technical standards and contributes to improving the quality and competitiveness of companies, their products and services. UNE is the body legally responsible for the development of standards in Spain.
BLACK HEALTH ALLIANCE	The Black Health Alliance is a community-led registered charity working to improve the health and well-being of Black communities in Canada. The alliance provides a platform for Black people to establish a common voice around systemic problems, and work to co-design and mobilize the tools, skills, partnerships and investment needed to implement solutions that improve health outcomes across Canada.
British Standards Institution (BSI)	BSI is the national standards body of the United Kingdom. It is a non-profit distributing organization and offers global services in the linked fields of standardization, system assessment, product certification, training and advisory services. BSI produces technical standards on a wide range of products and services and also supplies certification and standards-related services to businesses.
Canadian Alliance on Mental Illness and Mental Health (CAMIMH)	CAMIMH is the national voice for mental health in Canada. CAMIMH is a member-driven alliance of 16 mental health groups comprised of health care providers and organizations that represent people with mental illness, their families and caregivers.
Canadian Centre for Substance Use and Addictions (CCSA)	CCSA is a non-governmental organization that provides national leadership on substance use advances solutions to address alcohol- and other drug-related harms.
Canadian Collaborative Mental Health Initiative (CCMHI)	CCMHI is a consortium of twelve national organizations with a mutual interest in the mental health and well-being of Canadians, working together to enhance the relationship and improve collaboration among health care providers, consumers, families and caregivers; and to improve consumer access to prevention, health promotion, treatment/ intervention and rehabilitation services in primary health care settings.

Canadian General Standards Board (CGSB)	CGSB is a federal government organization that offers client-centred, comprehensive standards development and conformity assessment services in support of the economic, regulatory, procurement, health, safety and environmental interests of its stakeholders. CGSB is accredited by SCC as a SDO and is also accredited as a product certification body and a management systems certification body.
Canadian Institute for Health Information (CIHI)	CIHI provides comparable and actionable data and information that are used to accelerate improvements in health care, health system performance and population health across Canada.
Canadian Mental Health Association (CMHA)	CMHA is a federated charity, which means a collective of organizations bound together by a brand and mission. Together, they identify and respond to Canada's most pressing mental health priorities. At the national level, they push for nationwide system and policy change. At the community level, millions of people in Canada rely on CMHA's extensive grassroots presence.
Canadian Research Initiative in Substance Misuse (CRISM)	CRISM is a national research consortium focused on substance use disorders, comprising five large interdisciplinary regional teams (nodes) representing British Columbia, the Prairie Provinces and Territories, Ontario, Québec, and the Atlantic Provinces. CRISM's mission is to translate the best scientific evidence into clinical practice and policy change.
Centre for Addiction and Mental Health (CAMH)	As Canada's largest mental health teaching hospital, CAMH sets the standards for care, research, education and leading social change.
Community Addictions Peer Support Association (CAPSA)	CAPSA is a national organization of subject matter experts, researchers and educators dedicated to changing approaches to Substance Use Health through training, education and consulting.
CSA Group (CSA)	CSA is a Canadian standards development organization, accredited by SCC. It is one of the largest standards development organizations in North America and has offices in Europe, and Asia. CSA's standardization activities have a wide focus, including areas such as construction, energy, health, ICT and transportation. CSA has published the Canadian adoptions of a large number of ISO standards.

Danish Standards Foundation (DANSK)	DS is a private, independent, non-governmental organization and serves as the national standardization organization of Denmark. DS offers standardization services in a variety of areas, ranging from the development of standards to the sale of standards and related publications. DS is a member of the ISO, IEC, CEN, CENELEC and ETSI.
DIGITAL GOVERNANCE STANDARDS INSTITUTE (DGSI) **(Previously known as the CIO Strategy Council)**	DGSI, part of the Digital Governance Council, is a Canadian standards development organization, accredited by SCC. The Institute enables greater trust and confidence in Canada's digital systems through developing technology governance standards collaboratively across a range of stakeholders. As a discipline, digital governance establishes the processes, policies, standards, and accountability needed to manage the effective and efficient use of technology across organizations and society.
Families for Addiction Recovery (FAR)	Families for Addiction Recovery is a national charity founded by parents of children who have struggled with addiction from their teens. Our goal is long term recovery for those with addiction and their families.
First Nations Health Authority (FNHA)	The First Nations Health Authority (FNHA) is the health and wellness partner to over 200 diverse First Nations communities and citizens across British Columbia (BC). FNHA works to transform and reform the way health care is delivered to First Nations in BC, and to undertake program and service delivery in a manner aligned with First Nations philosophies, perspectives and ways of being.
First Peoples Wellness Circle (FPWC)	FPWC is an Indigenous-led national not-for-profit dedicated to enhancing the lives of First Peoples in Canada by addressing healing, wellness, and mental wellness barriers. The organization's purpose is to walk with and support First Peoples and communities to share collective intelligence for healing, peace-making, and living a good life.
Foundry	Foundry is a province-wide network of integrated health and wellness services for young people ages 12-24.
German Institute for Standardization (DIN)	DIN is the German national organization for standardization and is the German ISO member body. DIN develops norms and standards for rationalization, quality assurance, environmental protection, safety and communication in various fields such as technology, science, industry, government and the public domain.

Health Canada	Health Canada is responsible for helping Canadians maintain and improve their health. It ensures that high-quality health services are accessible, and works to reduce health risks.
Health Standards Organization (HSO)	HSO is a registered not-for-profit organization and an SCC-accredited Standards Development Organization. HSO's focus is on developing standards, assessment programs and other tools to help care providers do what they do best: save and improve lives.
Homewood Research Institute (HRI)	HRI is an independent national charity dedicated to research that transforms mental health and substance use treatment in Canada and beyond.
INDIGENOUS SERVICES CANADA (ISC)	Indigenous Services Canada (ISC) works collaboratively with partners to improve access to high quality services for First Nations, Inuit and Métis. Their vision is to support Indigenous peoples to independently deliver services and address the socio-economic conditions in their communities.
International Electrotechnical Commission (IEC)	The International Electrotechnical Commission is an international standards organization that prepares and publishes international standards for all electrical, electronic and related technologies. IEC has many joint technical committees with ISO, most notably ISO/IEC JTC 1.
International Organization for Standardization (ISO)	ISO is an independent, non-governmental international organization. It brings global experts together to agree on the best ways of doing things. Through ISO's members (the national standards bodies in 170 different countries) experts from all over the world are brought together to develop International Standards.
International Telecommunication Union – Telecommunication Standardization Sector (ITU-T)	ITU-T is one of the three sectors of the International Telecommunication Union (ITU), a specialized agency of the United Nations for information and communication technologies (ICT). ITU-T coordinates standards for telecommunications and ICT and has a number of study groups and focus groups within its structure.
INUIT TAPIRIIT KANATAMI	Serve as a national voice protecting and advancing the rights and interests of Inuit in Canada.
MENTAL HEALTH COMMISSION OF CANADA (MHCC)	The MHCC is a national not-for-profit corporation and a registered charity. They are supported by funding from Health Canada, partnerships with federal, provincial and

	territorial governments, foundations, private sector organizations, and donations from the public. MHCC offers accessible training programs that support mental health in communities and workplaces and lead research and program initiatives that emphasize people-centred values like lived and living experience.
METIS NATIONAL COUNCIL	The Métis National Council works to support and enrich the lives of Métis people across the homeland. The Métis National Council is committed to working with its Governing Members, the Federal and Provincial governments, and NGOs to advance Métis Nation priorities and development of solutions which support the inclusion of Métis knowledge in program and policy development. The Métis Nation and Canada continue the implementation of shared priorities, and remain committed to the recognition of rights, respect, cooperation and partnership on a Nation to Nation basis.
MOOD DISORDERS SOCIETY OF CANADA	Mood Disorders Society of Canada (MDSC) has evolved to become one of Canada's best-connected mental health Non-Governmental Organizations (NGO) with a demonstrated track record for forging and maintaining meaningful and sustained partnerships with the public, private and non-profit sectors throughout Canada. MDSC was formally launched and incorporated in 2001 with the overall objective of providing people with mood disorders with a strong, cohesive voice at the national level to improve access to treatment, inform research, and shape program development and government policies with the goal of improving the quality of life for people affected by mood disorders.
NATIONAL COLLABORATING CENTRE FOR DETERMINANTS OF HEALTH	At the National Collaborating Centre for Determinants of Health (NCCDH), we provide the Canadian public health community with knowledge and resources to take action on the social determinants of health, to close the gap between those who are most and least healthy. We work with the public health field to move knowledge into action—in practice, in policy and in decision making—to achieve societal improvements that result in health for all. We are one of six national collaborating centres funded through a Public Health Agency of Canada program.

NATIONAL COLLABORATING CENTRE FOR INDIGENOUS HEALTH	The National Collaborating Centre for Indigenous Health (NCCIH) is a national Indigenous organization established in 2005 by the Government of Canada and funded through the Public Health Agency of Canada (PHAC) to support First Nations, Inuit, and Métis public health renewal and health equity through knowledge translation and exchange. The NCCIH is hosted by the University of Northern BC (UNBC) in Prince George, BC.
National Institute for Health and Care Excellence (NICE)	NICE helps practitioners and commissioners get the best care to patients, fast, while ensuring value for the British taxpayer. NICE evaluate new health technologies, considering clinical effectiveness and value for money. NICE also produces useful and usable guidance, helping health and care practitioners deliver the best care.
PAUKTUUTIT INUIT WOMEN OF CANADA	Pauktuutit is the national representative organization of Inuit women in Canada and is governed by a 15-member Board of Directors from across Canada. We foster greater awareness of the needs of Inuit women, advocate for equality and social improvements, and encourage Inuit women’s full participation in the community, regional and national life of Canada.
PUBLIC HEALTH AGENCY OF CANADA	The Public Health Agency of Canada is part of the federal health portfolio. Its activities focus on preventing disease and injuries, responding to public health threats, promoting good physical and mental health, and providing information to support informed decision making.
Royal Netherlands Standardization Institute (NEN)	The Royal Netherlands Standardization Institute (NEN) is a private, non-profit organization, NEN participates in the development of international and European standards, and where appropriate, of national standards. It is the central point in the Netherlands for information on standards and standards development.
Search Institute	Search Institute is a nonprofit organization that collaborates with partners to conduct and apply research that promotes positive youth development and advances equity.
Standards New Zealand (SNZ)	SNZ is the national standards body for New Zealand and is a business unit within the Ministry of Business, Innovation and Employment. SNZ specializes in managing the development of standards and publishes and sells New Zealand, joint Australian-New Zealand, and international standards.
Swiss Association for Standardization (SNV)	The Swiss Association for Standardization (SNV) is a non-profit organization under private law. SNV is responsible for coordination, publication, distribution, registration and sale of

	standards and relevant documents, and representing sectoral and national interests in the field of standardization. SNV is a member of ISO, the International Organization for Standardization and of CEN, the European Committee for Standardization.
THE CANADIAN PAEDIATRIC SOCIETY	CPS is a voluntary professional association that represents paediatricians, paediatric subspecialists, paediatric residents, and others who work with and care for children and youth. The CPS is governed by an elected Board of Directors representing all provinces and territories.
THE CANADIAN PAIN SOCIETY	The Canadian Pain Society connects healthcare professionals, scientists, researchers, policymakers, and people with lived experience through evidence-based education. Our purpose is to drive innovation through advancement and advocacy and revolutionize access and care for those living with pain.
THE ORGANISATION FOR THE REVIEW OF CARE AND HEALTH APPS	Their mission is to put the power of digital health safely into the hands of everyone who needs it.
THUNDERBIRD PARTNERSHIP FOUNDATION	The Thunderbird Partnership Foundation is a non-profit organization that is committed to working with First Nations to further the capacity of communities to address substance use and addiction. We promote a wholistic approach to healing and wellness that values culture, respect, community, and compassion. Our top priority is developing a continuum of care that would be available to all Indigenous people in Canada.
United Nations (UN)	The United Nations is an international organization made up of 193 Member States. The UN is where all the world's nations can gather together, discuss common problems, and find shared solutions that benefit all of humanity.
WELLESLEY INSTITUTE	Wellesley Institute works in research and policy to improve health and health equity in the GTA through action on the social determinants of health. Wellesley Institute is a registered non-profit charity.
World Health Organization (WHO)	WHO is the United Nations agency that connects nations, partners and people to promote health, keep the world safe and serve the vulnerable – so everyone, everywhere can attain the highest level of health.

Annex J

Methodology for Developing the MHSUH Standards Landscape

The roadmap's focus was guided by the priorities developed through federal, provincial, and territorial consensus in 2017. Activities for the development of the roadmap have been framed under four broad domains: (1) Foundation and Integration, (2) Primary Health Services Integration, (3) Children and Youth, and (4) People with Complex Needs. Within those domains, broad topical areas of relevance to standards and conformance programs for MHSUH have been identified (see Diagram 1).

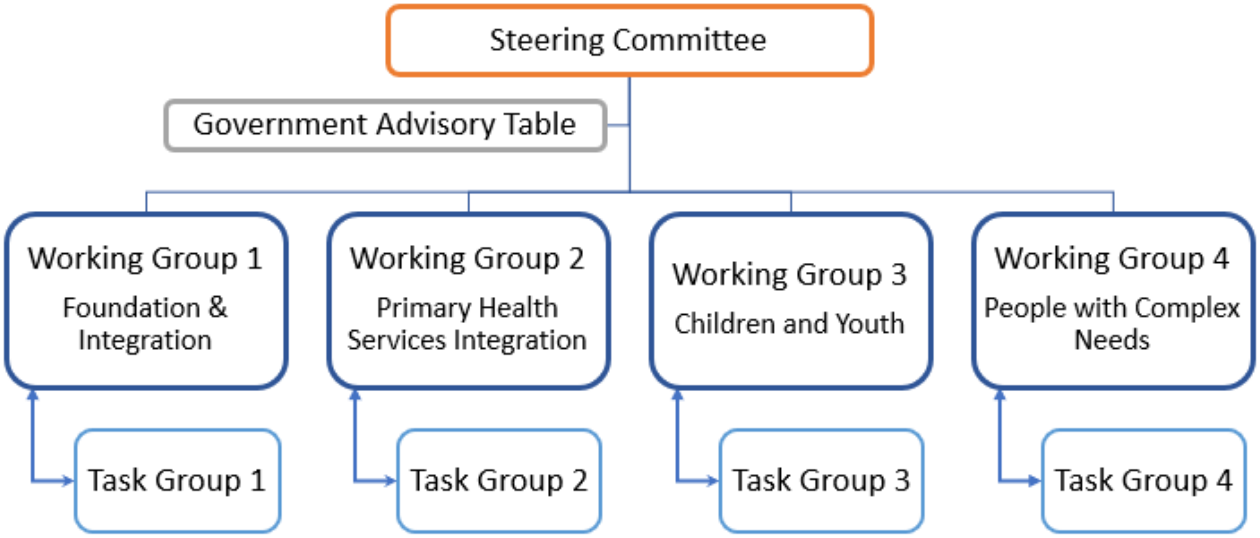

Diagram 1: Structure of MHSUH Standardization Collaborative

Between May to November 2022, the Collaborative Secretariat, Steering Committee and working groups discussed and confirmed priority areas for the first version of the roadmap (see diagram 2). The Steering Committee, working groups, and later task groups held virtual meetings over the last year to describe and scope the key issues, inventory existing standards, conduct the gap analysis and draft the roadmap.

Understanding the relevance of standards to the MHSUH Standardization Collaborative was a major undertaking, given the breadth of the topic and the diverse range of perspectives. Consequently, a participatory research methodology was adopted which enabled all working group (WG) and task group (TG) members to be involved as subject experts and to bring their perspectives into the knowledge-production process, i.e., the development of the standards roadmap.[1]

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[1] Bergold, J., & Thomas, S. (2012). Participatory research methods: A methodological approach in motion. *Historical Social Research/Historische Sozialforschung*, 191-222.

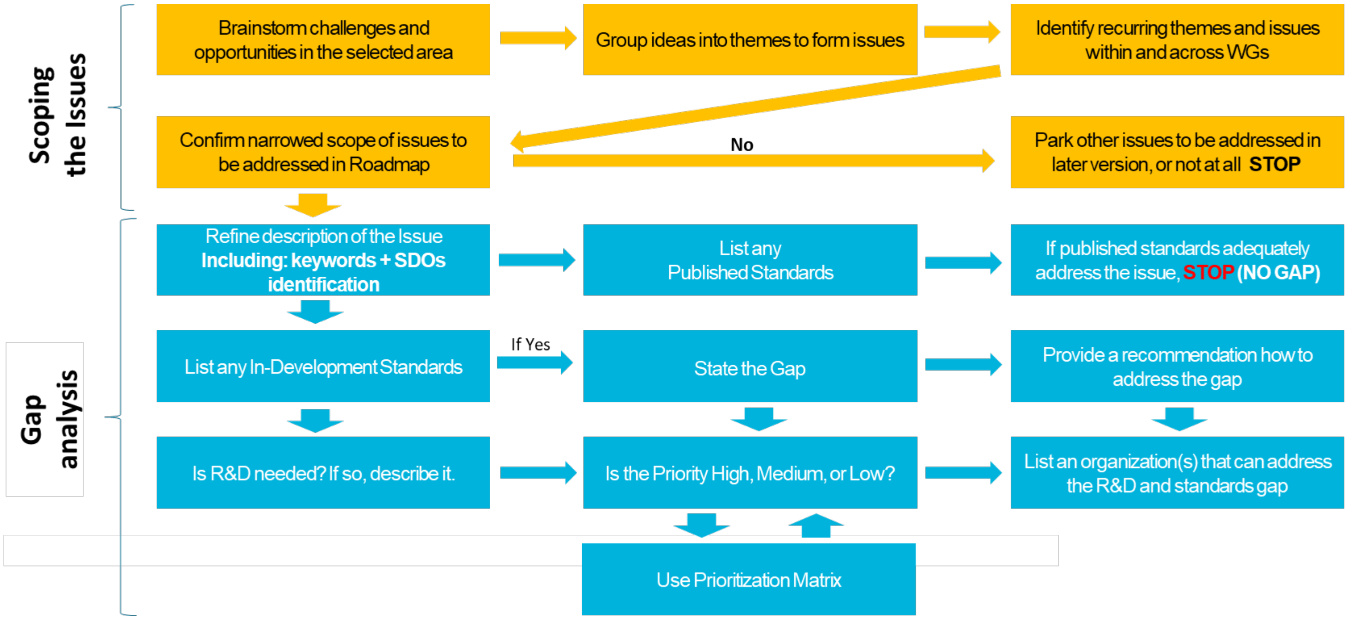
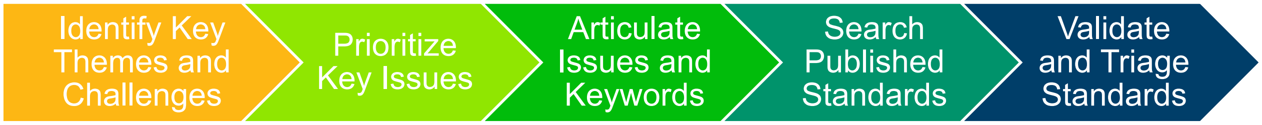


Diagram 2: Scoping and defining the gaps process flow.

Specifically, each working group and task group followed the following steps to map out the landscape of published standards in accordance with their scope.



Identifying Key Themes and Challenges

Members under each WG and TG worked together to brainstorm key themes, challenges, gaps and opportunities under their respective working group scope. Broadly speaking, the following questions were discussed:

- What are the social determinants, technological, economic, environmental, political, and other value-related needs related to MHSUH?
- What key changes have occurred that pose challenges in these areas?
- Are there any opportunities that we want to pursue but need standardization solutions to facilitate the ability to pursue them?

Results of each brainstorming session were analyzed and grouped into themes to form high-level issues. Subsections of each issue, recurring themes and issues within and across WGs and TGs were also identified, which were further categorized into 24 issues.

Articulate Issues and Keywords

Each WG and TG discussed the identified issues assigned to their groups and completed the scoping and description of issues. This included:

- Describing the issue and why it is important from a MHSUH perspective;

- Proposing a list of keywords to be used to identify standards associated with the issues/ challenges; and
- Identifying relevant organizations and standards development organizations (SDOs) that are applicable to the issue and within the scope of the roadmap.

This led to a list of 364 keywords across 24 issues.

Search Published Standards

The Collaborative Secretariat took the list of keywords and searched for relevant standards on EWB, a third-party database that provides codes and standards from more than 200 SDOs cross the world.[2] A few criteria were set to identify standards that are most relevant to the MHSUH Standardization Collaborative, including:

- Only search for active and latest edition of standards;
- Only search for English and French standards;
- Duplicate standards identified by different keywords but under the same issue were removed, but duplications across different issues were kept since they addressed different topics; and
- Multiple adoptions of the same standards were removed, only keeping the original international standards being adopted, or alternatively, a single version of a national adoption.

In total, about 1,116 standards were identified across 24 issues after removing duplications, as well as 262 documents of various other types for a total of 1,378 documents.

In parallel to the meeting discussions and the selection of Key issues, the working group and task group members were asked to share standards and other documents relevant to the Key Issues. These documents were also added to the Standard Landscape.

Validate and Triage Standards

The next step of the process was to validate and triage standards identified through the EWB search to remove any irrelevant standards and ensure that relevant standards were not missed. Each document of the list of standards was reviewed and rated as per the following criteria:

Tier	Description
I	The standard, based on the citation and title, matches not only the keyword but also the description of the issue and looks like its use would address the challenges identified.
II	The standard, based on the citation and title, partially matches either the keyword and/or the description of the issue, where it may either partially address the challenge identified or be useful as a reference in creating a standard to address the challenge identified.
III	The standard, based on the citation and title, would only be useful to the issue in a very limited scope, such as a specific sector or a niche approach.
IV	The standard, based on the citation and title, has no relevance to the issue and the keyword.

The Collaborative Secretariat, with support from WGs and TGs were then asked to perform the gap analysis evaluation of existing and needed standards, specifications and conformance programs for each

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[2] Accuris. Engineering Workbench: Standards, Codes & Specs. Access at: https://ihsmarkit.com/products/standards-codes-specs.html

issue. A “gap” was defined as meaning that no published standard, specification, etc. exists that covers the particular issue in question. Where gaps were identified and described, the Collaborative Secretariat with the support of working groups and task groups provided a recommendation for what should be done to fill the gap, and an organization(s) – e.g., an SDO or research organization – that potentially could carry out the R&D and/or standards development based on its current scope of activity. Where more than one organization was listed, there was no significance to the order in which the organizations were listed.

This roadmap is supplemented by the *MHSUH Landscape*, a table of standards that are directly or peripherally related to the issues described in the roadmap and can be found in Annex K.

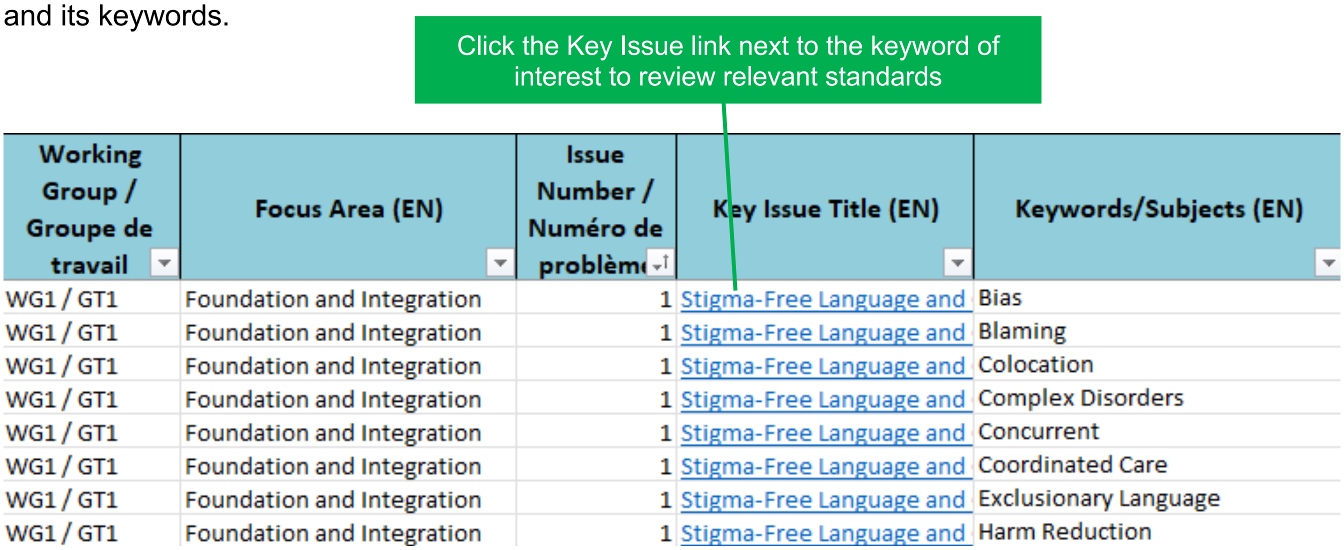
Annex K

The MHSUH Standardization Landscape

Instructions on How to Review Standardization Landscape

(click here to download the Excel File)

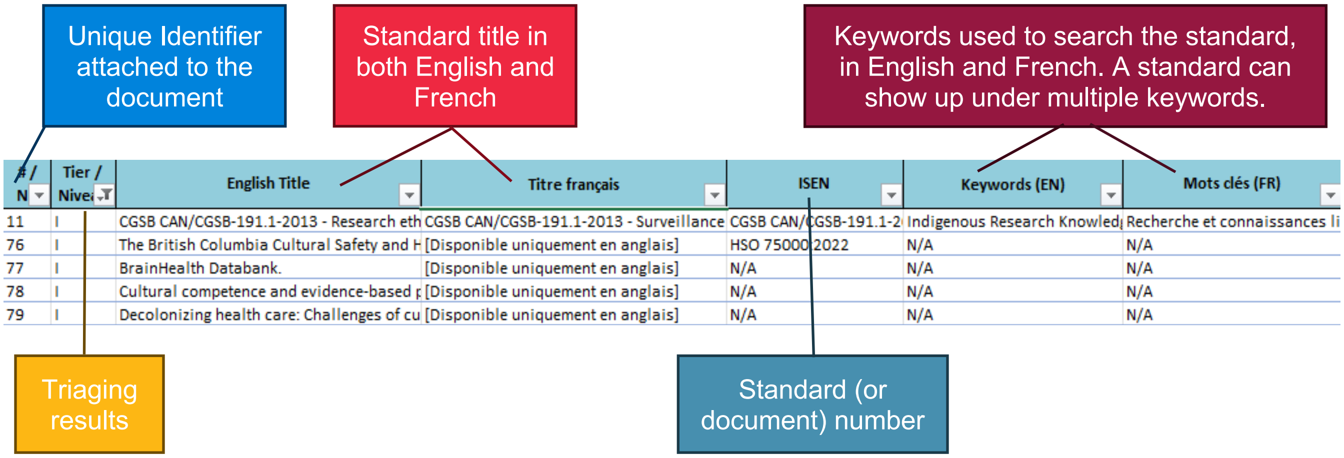
The Index page provides a summary of all keywords under the 24 Issues identified.
Clicking the Key Issue Title will bring you to the list of the standard documents related to that Key Issue and its keywords.



Click the Key Issue link next to the keyword of interest to review relevant standards

Working Group / Groupe de travail	Focus Area (EN)	Issue Number / Numéro de problèm	Key Issue Title (EN)	Keywords/Subjects (EN)
WG1 / GT1	Foundation and Integration	1	Stigma-Free Language and	Bias
WG1 / GT1	Foundation and Integration	1	Stigma-Free Language and	Blaming
WG1 / GT1	Foundation and Integration	1	Stigma-Free Language and	Colocation
WG1 / GT1	Foundation and Integration	1	Stigma-Free Language and	Complex Disorders
WG1 / GT1	Foundation and Integration	1	Stigma-Free Language and	Concurrent
WG1 / GT1	Foundation and Integration	1	Stigma-Free Language and	Coordinated Care
WG1 / GT1	Foundation and Integration	1	Stigma-Free Language and	Exclusionary Language
WG1 / GT1	Foundation and Integration	1	Stigma-Free Language and	Harm Reduction

The Compendium sheet contains all the documents found for the collaborative landscape. The other 24 sheets contain standards and documents found that are related to each Issue (one sheet per Issue). The last sheet contains other documents found that are related to the overall Collaborative.
Below is a quick overview of the structure in the Key Issue sheets.



Unique Identifier attached to the document

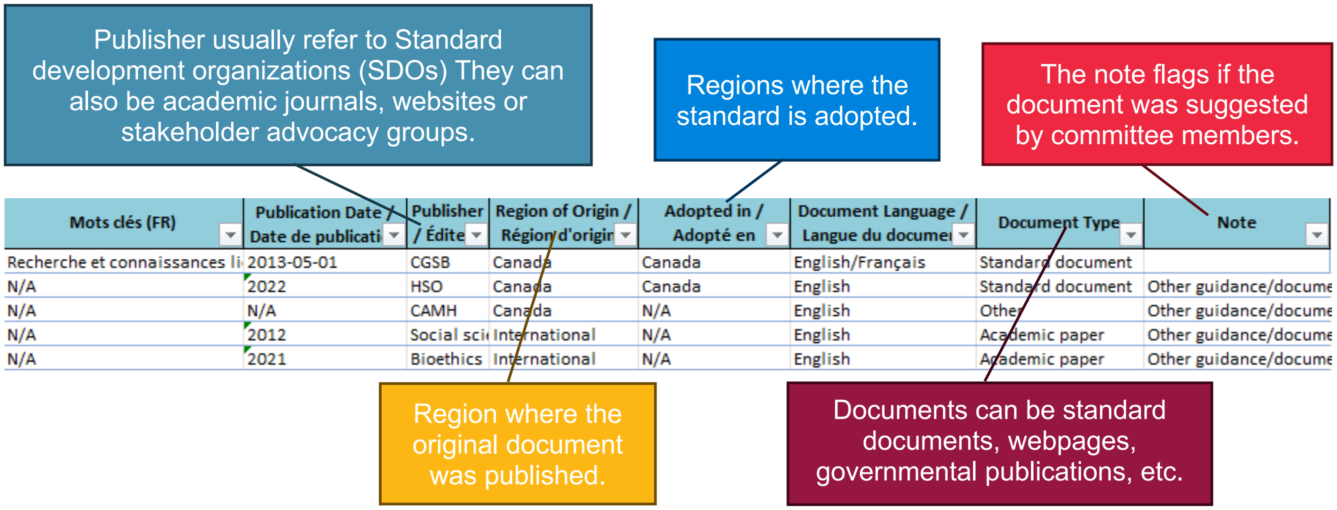
Standard title in both English and French

Keywords used to search the standard, in English and French. A standard can show up under multiple keywords.

# / N	Tier / Nivea	English Title	Titre français	ISEN	Keywords (EN)	Mots clés (FR)
11	I	CGSB CAN/CGSB-191.1-2013 - Research eth	CGSB CAN/CGSB-191.1-2013 - Surveillance	CGSB CAN/CGSB-191.1-2	Indigenous Research Knowled	Recherche et connaissances li
76	I	The British Columbia Cultural Safety and H	[Disponible uniquement en anglais]	HSO 75000:2022	N/A	N/A
77	I	BrainHealth Databank.	[Disponible uniquement en anglais]	N/A	N/A	N/A
78	I	Cultural competence and evidence-based p	[Disponible uniquement en anglais]	N/A	N/A	N/A
79	I	Decolonizing health care: Challenges of cu	[Disponible uniquement en anglais]	N/A	N/A	N/A

Triaging results

Standard (or document) number



Publisher usually refer to Standard development organizations (SDOs) They can also be academic journals, websites or stakeholder advocacy groups.

Regions where the standard is adopted.

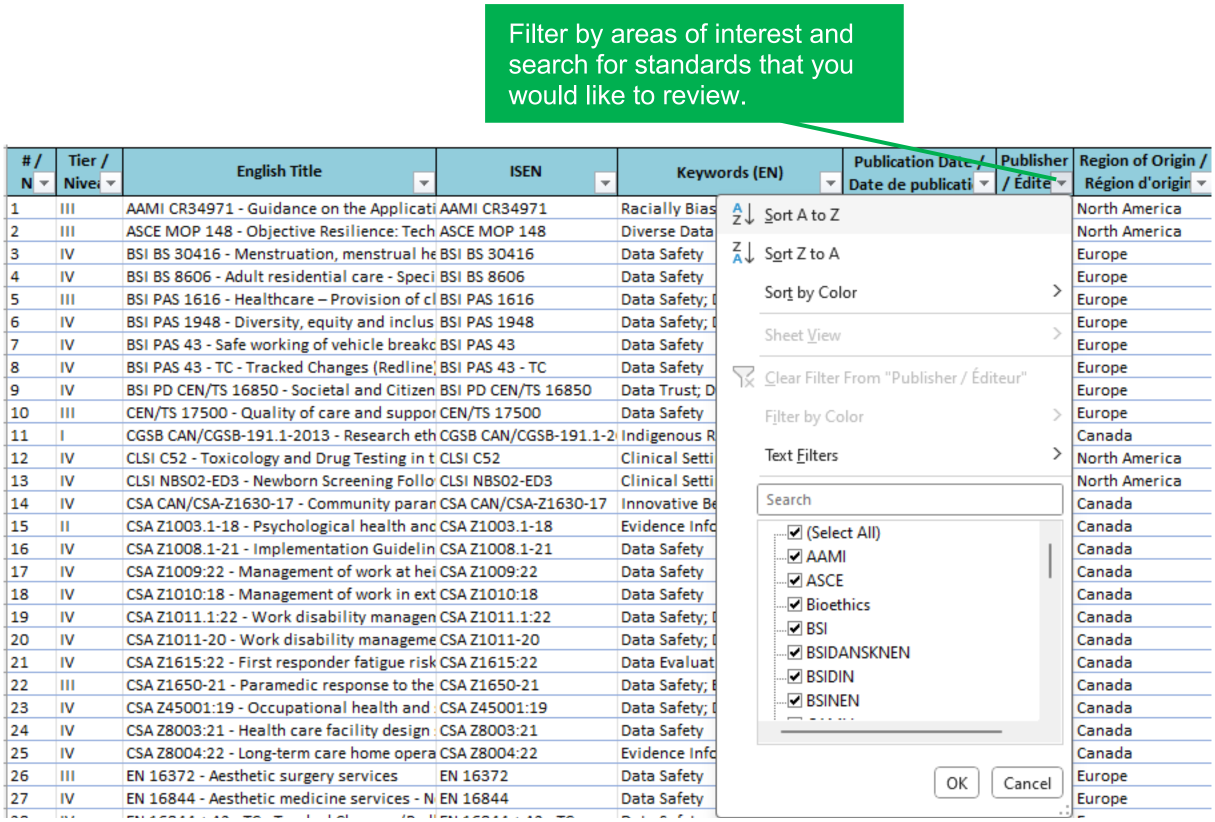
The note flags if the document was suggested by committee members.

Mots clés (FR)	Publication Date / Date de publicati	Publisher / Édite	Region of Origin / Région d'origir	Adopted in / Adopté en	Document Language / Langue du documer	Document Type	Note
Recherche et connaissances li	2013-05-01	CGSB	Canada	Canada	English/Français	Standard document	
N/A	2022	HSO	Canada	Canada	English	Standard document	Other guidance/docume
N/A	N/A	CAMH	Canada	N/A	English	Other	Other guidance/docume
N/A	2012	Social sci	International	N/A	English	Academic paper	Other guidance/docume
N/A	2021	Bioethics	International	N/A	English	Academic paper	Other guidance/docume

Region where the original document was published.

Documents can be standard documents, webpages, governmental publications, etc.

To review standards under specific Issues, you can filter by Title, ISEN (standard number), publisher (i.e., the standard development organizations) or by keywords. Please use the Filter function in Excel to filter areas of interest and search for standards that you would like to review.



Filter by areas of interest and search for standards that you would like to review.

# / N	Tier / Nivea	English Title	ISEN	Keywords (EN)	Publication Date / Date de publicati	Publisher / Édite	Region of Origin / Région d'origir
1	III	AAMI CR34971 - Guidance on the Applicati	AAMI CR34971	Racially Bias			North America
2	III	ASCE MOP 148 - Objective Resilience: Tech	ASCE MOP 148	Diverse Data			North America
3	IV	BSI BS 30416 - Menstruation, menstrual he	BSI BS 30416	Data Safety			Europe
4	IV	BSI BS 8606 - Adult residential care - Speci	BSI BS 8606	Data Safety			Europe
5	III	BSI PAS 1616 - Healthcare – Provision of cl	BSI PAS 1616	Data Safety;			Europe
6	IV	BSI PAS 1948 - Diversity, equity and inclus	BSI PAS 1948	Data Safety;			Europe
7	IV	BSI PAS 43 - Safe working of vehicle breakc	BSI PAS 43	Data Safety			Europe
8	IV	BSI PAS 43 - TC - Tracked Changes (Redline)	BSI PAS 43 - TC	Data Safety			Europe
9	IV	BSI PD CEN/TS 16850 - Societal and Citizen	BSI PD CEN/TS 16850	Data Trust; D			Europe
10	III	CEN/TS 17500 - Quality of care and suppor	CEN/TS 17500	Data Safety			Europe
11	I	CGSB CAN/CGSB-191.1-2013 - Research eth	CGSB CAN/CGSB-191.1-2	Indigenous R			Canada
12	IV	CLSI C52 - Toxicology and Drug Testing in t	CLSI C52	Clinical Setti			North America
13	IV	CLSI NBS02-ED3 - Newborn Screening Follo	CLSI NBS02-ED3	Clinical Setti			North America
14	IV	CSA CAN/CSA-Z1630-17 - Community paran	CSA CAN/CSA-Z1630-17	Innovative Be			Canada
15	II	CSA Z1003.1-18 - Psychological health anc	CSA Z1003.1-18	Evidence Info			Canada
16	IV	CSA Z1008.1-21 - Implementation Guidelin	CSA Z1008.1-21	Data Safety			Canada
17	IV	CSA Z1009:22 - Management of work at hei	CSA Z1009:22	Data Safety			Canada
18	IV	CSA Z1010:18 - Management of work in ext	CSA Z1010:18	Data Safety			Canada
19	IV	CSA Z1011.1:22 - Work disability managen	CSA Z1011.1:22	Data Safety;			Canada
20	IV	CSA Z1011-20 - Work disability manageme	CSA Z1011-20	Data Safety;			Canada
21	IV	CSA Z1615:22 - First responder fatigue risk	CSA Z1615:22	Data Evaluat			Canada
22	III	CSA Z1650-21 - Paramedic response to the	CSA Z1650-21	Data Safety;			Canada
23	IV	CSA Z45001:19 - Occupational health and	CSA Z45001:19	Data Safety;			Canada
24	IV	CSA Z8003:21 - Health care facility design	CSA Z8003:21	Data Safety			Canada
25	IV	CSA Z8004:22 - Long-term care home opera	CSA Z8004:22	Evidence Info			Canada
26	III	EN 16372 - Aesthetic surgery services	EN 16372	Data Safety			Europe
27	IV	EN 16844 - Aesthetic medicine services - N	EN 16844	Data Safety			Europe