



Improving Access and Coordination of Mental Health and Addiction Services: A Provincial Strategy for all Manitobans

***VIRGO PLANNING AND EVALUATION CONSULTANTS INC.
TORONTO, ONTARIO***

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The VIRGO Consultant Team

*“We are all on the same river but
paddling in different boats”.*

- Strategy discussion participant

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Executive Summary

1.0 Introduction and Background

The Government of Manitoba, as represented by the Minister of Health, Seniors and Active Living, has commissioned a focused provincial Strategic Plan that will look at ways to improve **access** and **coordination** of services (described below) for individuals with substance use/addiction and mental health problems and illnesses (SUA/MH). In the context of informing improvements with respect to access and coordination, the Strategy must support relevant considerations for service delivery across a range of high need populations and across the spectrum of approaches, including prevention and harm reduction, inter-sectoral partnerships, human resources and knowledge exchange.

The key focus of the Strategic Plan:

Access to services is a complex concept and experts agree that several aspects are relevant. If services are available and in adequate supply, then the opportunity to obtain service exists, and a population may *'have access'* to services. However, access is also related to the *affordability, physical accessibility and acceptability* of services. Furthermore, services available must be relevant and effective if the population is to *'gain access to satisfactory health outcomes'*. The availability of services, and barriers to access, have to be considered in the context of the differing perspectives, health needs and material and cultural settings of diverse groups in society.

Coordination of services can be considered at two inter-related levels. One can consider coordination of individual or family treatment and recovery support (e.g., the work of a service coordinator) as well as coordination of the overall network or system of service providers (e.g., the work of an inter-agency planning committee). A definition that is appropriate for both levels refers to the process by which multiple services and recovery supports, often provided by multiple sectors and service providers, are synchronized to address the needs and strengths of each person and family seeking assistance.

2.0 Approach

The VIRGO team, led by Dr. Brian Rush, implemented a comprehensive quantitative and qualitative approach to an assessment of system-wide strengths and challenges with respect to service access and coordination. The approach involved:

- *Review of evidence:* The extant research evidence concerning both SUA/MH system design and effective service-level interventions was synthesized.
- *Data indicators:* A wide range of data were compiled to establish the nature and level of needs related to SUA/MH.
- *Document review:* Approximately 275 documents were analysed, including previous strategic planning work and reports of many projects and reviews.
- *Consultations and discussions:* Approximately 350 stakeholders from multiple sectors and services were engaged in interviews/group discussions or were invited to submit written statements.
- *Validation events:* Highlights of “what we heard” in the above consultations and discussions were shared in a series of validation events to ensure the emergent findings and implications resonated with the various stakeholder groups.
- *On-line survey:* Two on-line surveys – one for service providers (n=1723) and another for the general public (n=2080) collected quantitative and qualitative perspectives about many aspects of the province’s SUA/MH services.
- *Data request:* Quantitative information from SUA/MH service providers was analyzed to inform an understanding of service capacity and utilization, wait times, and occupancy rates, as well the development of an exhaustive “system mapping” exercise. *Advisory and project management processes:* The VIRGO team gave regular updates to the MHSAL Project Logistics Committee and presentations to the Project Reference Group, the latter being a group of key stakeholders and leaders offering ongoing advice on the process of the review and interpretation of findings.

3.0 The CONTEXT: Recognizing and responding to the need for investment in SUA/MH

International and national context

A decade ago the Surgeon General of the United States stated that “*there is no health without mental health.*” This mantra has since resonated globally and the World Health Organization (WHO) has been a particularly important champion for the message that mental health is an integral and essential component of health. Mental health has come to be seen as a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities.

As in all parts of the world, the pain and suffering of Canadian individuals and families experiencing SUA/MH challenges translates into significant costs to society at large, including a significant drain on the public purse. The most recent estimates of the economic burden of mental illness in Canada, including SUA, is well over \$50 billion annually. For SUA alone, the economic burden on services such as health care and law enforcement, and the loss of productivity in the workplace or at home resulting from premature death and disability, tallied to an overall social cost in Canada in 2002 of \$39.8 billion.

Many reports also highlight the high rates of SUA/MH among Canadian children and youth. There are also many national indicators of the unique challenges faced by Indigenous people with respect to SUA/MH. It is important to keep in mind that Indigenous health status in Canada, including mental wellness, must be interpreted in the context of the social determinants of health and historical trauma.

International research is unequivocal in its support for the effectiveness of SUA/MH services, including services for people experiencing co-occurring challenges. It is also critically important for policy makers and funders to recognize that the financial return of investment in services, including prevention and health promotion efforts, is significant, thereby makes an exceptionally strong business case for investment in treatment and support. Experts agree it's now a matter of government taking that seriously and acting on the evidence.

To reflect the growing concern over the level of need, as well as the human and economic consequences, important national organizations, including the Mental Health Commission of Canada (MHCC) and the Canadian Centre on Substance Use and Addiction (CCSA), have articulated the importance of a broad **“all of government”** and **“all of society”** response. Importantly, SUA/MH has been declared a national priority such that the 2017/18 federal budget confirmed that \$5 billion will be transferred to provincial and territorial governments over the next 10 years to improve access to services and improve health outcomes. As well, long-standing Indigenous issues have also been declared a priority at the national level; evident in part by the work of the Truth and Reconciliation Commission, the National Inquiry into Missing and Murdered Indigenous Women and Girls, and new funding opportunities such as those under the umbrella of Jordan's Principle.

Manitoba context

In Manitoba, the SUA/MH sectors have been in transition for the past two decades with several significant strategic planning processes undertaken and changes made to specific services, including the closure of the Brandon Mental Health Centre, re-direction of resources to community programs in the local health regions, the establishment of Selkirk Mental Health Centre (SMHC) as a provincial centre to address the needs of the long term mentally ill

population, the transfer of patients to community resources, and implementation of the Co-Occurring Disorder Initiative (CODI).

This review was undertaken in the context of significant recent changes in the SUA/MH system in Manitoba, including the creation of the new Provincial Health Organization, also known as Shared Health (SH); new federal funding opportunities resulting in new services being developed for First Nations communities; and responses to the tragic opioid overdose crisis in the province and the rapidly growing use of, and complex consequences associated with, crystal methamphetamine. Major service changes either undertaken (e.g., consolidation of emergency departments in the WRHA) or planned (e.g., additional PACT teams).

This review of past and current work also highlights that, while some investments have been made in recent years to enhance the province's SUA/MH system, these enhancements have been made by multiple stakeholders in the system and without the benefit of an integrated, comprehensive provincial plan. This reminds us again of the need for strong collaboration and governance and the high interest in the development of this new provincial Strategy to, not only fit into the new health system transformation, but also to present a unifying vision and identify priorities to guide future investments.

4.0 The NEED: What is the burden of SUA/MH on Manitobans?

Needs are extremely high: Manitoba stands out as the highest or very high on almost all SUA/MH need indicators, including those related to health, social and justice-related factors. Behind the “numbers” lies a huge financial drain on the province as well as an often tragic physical and emotional drain on communities, families and individual Manitobans. Taken together, the overall level of need clearly signals a call to action.

Needs are costly: A convincing economic argument is made that responding to this call for action with wise, evidence-informed investments will return a positive economic benefit. Comparing to other provinces, and in the context of the high need relative to other jurisdictions, Manitoba’s lower contribution to SUA/MH, further reinforces the call to action from a “business case” perspective. Doing nothing is itself costly. That being said, investment is not only about financial resources, but also includes streamlining processes for maximum value.

Needs are population and region/community specific: The regional variability in a large number of need indicators, and the association with specific disparity indicators and populations, including Manitoba’s Indigenous people, is critically important in the pursuit of solutions. This includes respecting cultural differences, understanding and acknowledging well-established root causes, and working diligently to deal with real and perceived jurisdictional issues.

Needs are evolving: Several indicators highlight the evolving nature of needs, for example, the trends in population growth and diversity, SUA, and increasing complexity of individual and community situations. Implications for system enhancement include the need for flexibility in key features of the system such as finely tuned surveillance systems, keeping services grounded as closely as possible in the community to be constantly on top of emergent trends, and embedding services in organizations that are adaptable and nimble.

Needs begin early in childhood: The data are compelling with respect to the impact of early childhood mental illnesses, and that treatment can help prevent SUA/MH in later years.

Needs are complex: Needs for SUA/MH services are intertwined in very complex ways with physical health, social and justice-related challenges. This has implications not only for ensuring person-centered, individualized treatment and support, but also calls for a “whole-system, multi-sectoral response”. A provincial governance model must support this multi-sectoral response and also facilitate a truly bio-psycho-social-spiritual/cultural approach, including the solutions for access and coordination specifically.

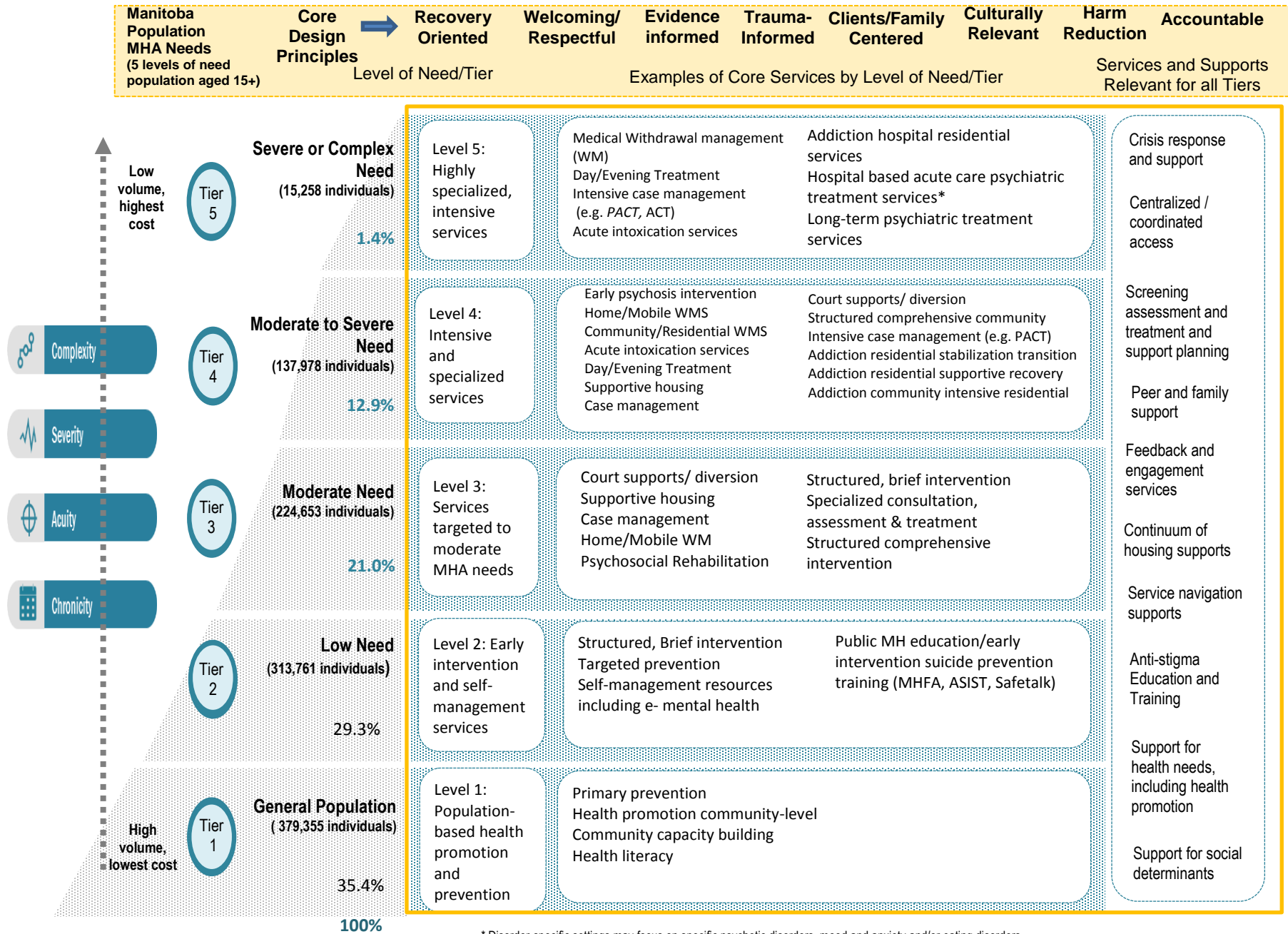
Needs do have solutions: As complex as this situation clearly is at a provincial, regional and local level, the evidence exists for responding effectively. The purpose of the Strategy is to articulate and prioritize these solutions in a way that facilitates improved access and coordination.

5.0 The GOAL – Key aspirational features of SUA/MH treatment and support systems

In the initial stage of the review process, the Consulting Team used a blended approach that identified key system features and principles, but with an eye to eventually articulating the broad vision of the Strategy, and related goals, principles and recommendations. These system features and principles, presented in the main report, also served as a template with which to compare the current system with an ideal state.

One key principle for service enhancement advanced in this review was for a population-health approach to system planning; an approach which aims to address the needs of the whole community across a full spectrum of severity and complexity. In this approach, the population is considered in sub-groups based on severity and complexity, often called “tiers”, and a corresponding set of treatment, support and other services aligned with each tier. This approach formed the basis for a conceptual framework to guide future system enhancements in the province.

Mental Health and Substance Use/ Addiction Treatment System Framework for Manitoba



* Disorder-specific settings may focus on specific psychotic disorders, mood and anxiety and/or eating disorders.

6.0 CURRENT STATE

The following is a brief summary of the overall system:

Investment is significant: The province's investment in SUA/MH related services is estimated at just over \$506.3 million, of which \$330.7 million or about 65% represents health funding. The health investment represents 5.1% of the total health investment and is below the national benchmark. The investment begs the important questions as to whether it is sufficient to meet the needs of the population and also whether outcomes are being maximized with the current system of services, in terms of both structure and processes.

Investment is multi-sectoral: Although the largest share of the investment comes through the MHSAL, it is very multi-sectoral in nature and involving several departments of the provincial government as well as FNIH at the federal level and the private sector. The multi-sectoral make-up of the system provides a strong foundation for a coordinated "whole of government/whole-of-society" response". This includes already strong engagement of sub-sectors within MHSAL, including primary care.

Multiple lines of funding and accountability: There are multiple players involved in the overall system of SUA/MH and, multiple service providers funded directly or indirectly by the MHSAL (e.g., RHAs, AFM, SMHC, MATC; many contracted providers). This reinforces observations made in several previous planning processes of an overly siloed system. The current structure of the provincial system of SUA/MH services and supports highlights the separation of the mental health and SUA services in the province.

Specialized services are the foundation: That being said, each "system" (SUA and mental health operates a continuum of services generally similar to that offered in many other Canadian jurisdictions, albeit with significant regional variation. Although there are significant gaps, and especially with respect to regional the current system provides a solid foundation on which a more accessible and coordinated system can be built.

Importance of community-based and other supports: The descriptive overview of the system also highlights the important role being played by community-based services and a range of self-help organizations. It is important to retain these strengths in the system while addressing broader issues related to structure, funding and accountability.

Federal/provincial relationships are critical: The significant involvement of FNIH-funded services highlights the importance of addressing jurisdictional issues so frequently noted in previous planning processes and documents reviewed, as well as the higher level of need among Indigenous people illustrated by the previous summary of need indicators across the province.

The following is a brief summary of highlights of the quantitative survey data:

Perceptions regarding access to services: Despite the investment in SUA/MH services and supports as shown in the preceding section, Manitoba's service providers and the general public alike expressed strong opinions about access to these services. This validates findings reported in previous planning processes and documents reviewed and for the first time, based on feedback from such a broad Manitoban constituency. Significant concerns were expressed about lack of information on how to access, the wait times involved, proximity from home, and the lack of flexibility in days and hours of service. Access to services and supports for family members and other loved ones was also seen as very limited.

Perceptions regarding coordination of services: Again, in spite of investments and efforts to create a continuum of services to meet a variety of needs, significant concerns were expressed about the ability of existing services to address the diversity, severity and complexity of people's needs. Significant concerns were also expressed about the extent to which the services are coordinated and support people's transitions across different services, again validating information from several previous planning processes.

Perceptions regarding program content and quality: The perceptions of the quality of current services was somewhat more positive than perceptions of access and coordination, although there were still concerns expressed about the lack of adaptability and flexibility, as well as limited choice. About half of the members of the general public that responded, and about a third of service providers, expressed a concern about the overall quality of services. This suggests that there is considerable room for improvement despite all the efforts and investments that have been made to date.

Perceptions regarding capacity in relation to need: Overwhelmingly, service providers and the general public alike expressed significant concerns that the available services and supports are not able to meet current demand. This underscores the feedback on wait times and other aspects of accessibility, and perhaps also the concerns expressed about coordination, content and overall quality. In short, a reasonable conclusion is that people are experiencing a system of services and supports that is essentially stretched too thin.

Gap Analysis

System supports related to access and coordination

- Prevention/work on the social determinants of health
- Limited application of population health approach; disparity between need/complexity and investment and capacity
- Provincial planning; too many silos; need for enhanced governance
- Multi-sectoral coordination (e.g., MHSAL/RHAs and CFS)

- Jurisdictional issues; support for Indigenous people; cultural aspects
- Impact of Children in Care, residential schools, and trauma
- Provincial performance metrics and standards
- Unconnected/outdated information systems
- Evidence base of services/scale up of successes
- Adaptability and flexibility for evolving needs
- Education/preparedness of service providers
- Workforce Development including wellness, training, peer support, and some specific profession-based enhancements

General System Characteristics

- Inconsistent application of recovery orientation
- Inconsistent application of harm reduction; need for provincial coordination and plan
- Children and youth are at risk; more focus needed on treatment and early intervention
- Limited MH and SUA collaboration and integration
- Room for improved collaboration with other sectors (e.g. primary care, hub models, services). Includes supports needed for collaboration
- Limited services for family/loved ones
- Wait times too long (general)
- Inequitable distribution of resources
- Gaps in awareness of what's available/how to access
- Gaps in proximity of services to home
- Lack of flexibility to meet needs/ more choice
- Lack of cultural sensitivity/relevance
- Gaps in continuum/core services (general)

Specific Gaps in Services and Transitions (examples)

- Withdrawal Management (all levels)
- Residential services with more flexible options, including flexible length of stay, treatment approaches
- More ORT needed with psychosocial supports
- Shortage of forensic beds
- High variability in core services
- Housing supports in community
- Transportation supports

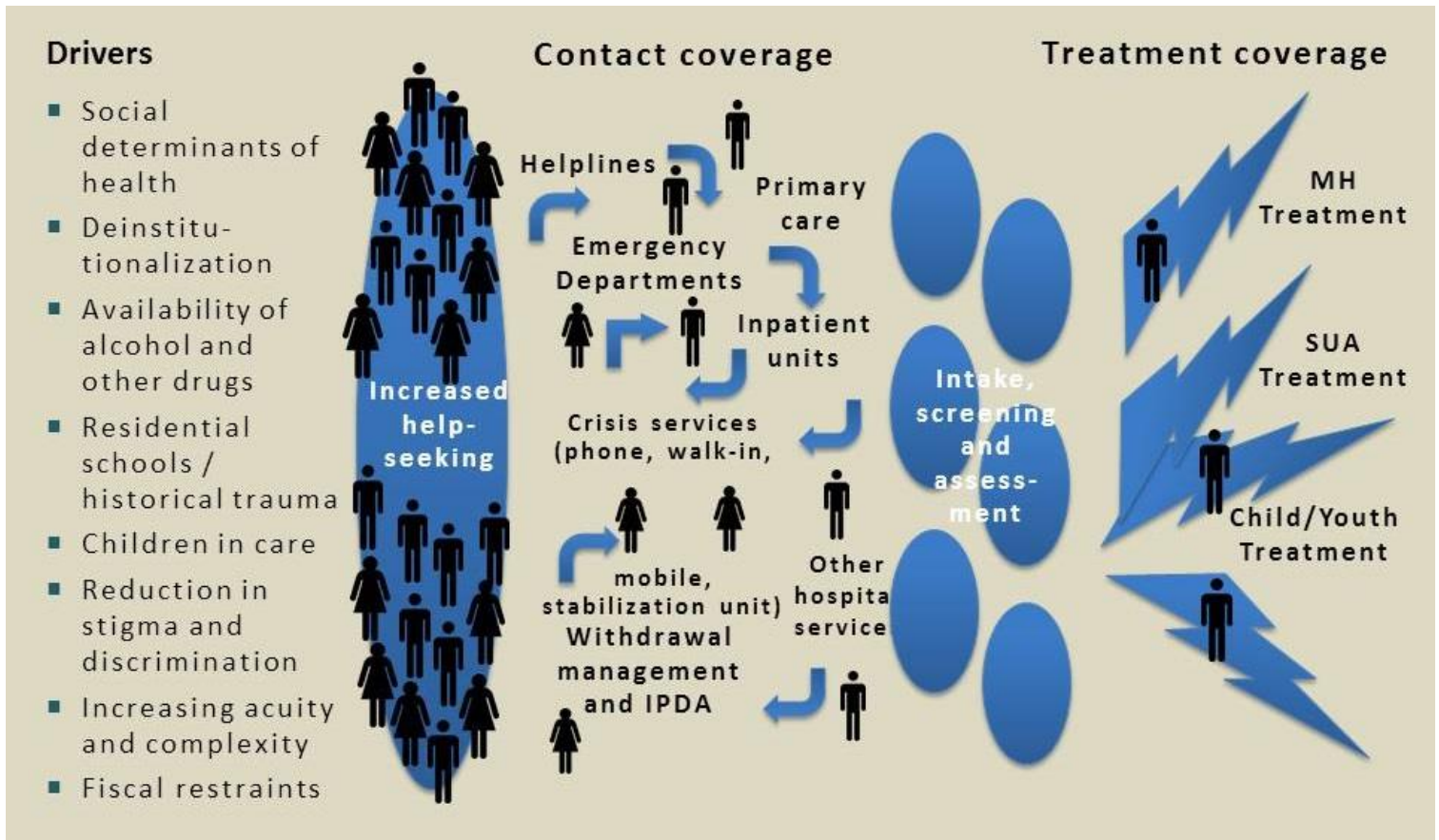
- More reliable and rapid access to crisis response/ psych assessment; SUA/MH support in EDs
- More streamlined and rapid access to treatment
- Lack of navigation support for access or transitions- youth to adults, corrections to community, hospital to community

Conceptual Diagram of the Current State

A conceptual diagram, presented below, summarizes the key elements of the overall “story” uncovered by the systems review and with respect to access and coordination. On the left side of the diagram are the “drivers” behind the nature and extent of help-seeking for SUA/MH challenges in the province, some of which are historical in nature.

The middle part of the graphic demonstrates how the system has responded somewhat reflexively in order to increase access points within available resources and at multiple points in the system. The structural, and to a very large extent, functional, separation of the provincial SUA/MH services has further exacerbated this situation, especially given the high levels of co-occurring disorders. The graphic tells a story of people cycling through, and around, multiple points of contact but relatively few getting through all the filters in place to get to effective treatment or therapeutic recovery supports.

Conceptual diagram illustrating the major challenges in access and coordination



7.0 FUTURE STATE: Priority Areas and Recommendations

The findings from the various components of the system review resulted in the framework for Manitoba’s SUA/MH Strategic Plan, presented the figure below. The framework is comprised of several parts: a **vision** for Manitoba, in regards to SUA/MH; a set of **principles** guiding the SUA/MH system; the **goals** to be achieved, the **strategic priorities** needed to deliver on those goals, and a set of **enabling supports** that, once built, will provide the foundation on which the SUA/MH system can deliver against its strategic priorities, goals, principles and vision.

Overview of the Strategic Plan.

Principles

Welcoming and respectful

Recovery-oriented

Person- and family-centred

Comprehensive continuum of evidence-informed services and support

Seamless delivery of integrated services across sectors, systems and the life span

Culturally relevant

Harm Reduction

Evidence-informed

Trauma-informed

High quality and innovative

Accountable

Population health-based planning, disparity reduction and diversity response

Goals

Access

Easy first contact, navigation support and engagement in an expanded, more flexible range of services and supports

Coordination

Delivery of more integrated, person-focused services that acknowledge people's families, communities, cultural connections and histories

Mental wellness of Manitoba's children and youth

Mental wellness of Manitoba's Indigenous peoples

Healthy and competent mental health and substance use workforce

Strategic priorities

Vision

All Manitobans enjoy the best possible mental health and well-being throughout life, and have welcoming, supportive and diverse communities in which to live, participate, recover and heal when facing mental health and substance use challenges

Enabling Supports

- Funding and accountability for quality outcomes
- Evidence generation / translation to policy and practice
- Surveillance, monitoring and performance management
- Community engagement and change management

In order to achieve the vision for the mental health and well-being of Manitobans, all stakeholders, including individuals, families, SUA/MH service providers, other related service delivery sectors, provincial government departments, and other levels of government, must work together and organize their efforts to deliver against the six (6) strategic priorities summarized below, and presented in detail, along with related recommendations, in [Section 7.4](#) of this report.

1.0 Population health-based planning, disparity reduction and diversity response

The future direction of the SU/MHA system in Manitoba needs to be informed by more provincial-level planning, based on a population health perspective that addresses the full range of needs among community members, and distributes resources across the province in a fair manner, according to need and unique regional circumstances. This is key to not only ensuring equitable access to treatment services and recovery supports, but also reinforces the need for a complementary effort focused on prevention and health promotion. An implication of our recommendations for a public health/population health approach to planning is the need for a “whole-of-government” and “whole-of society”. This response is critical for enhancing partnerships that significantly extend the reach and effectiveness of the specialized SUA/MH services and supports, which, on their own, cannot meet the full spectrum of community need. This response must also speak to the needs of all Manitobans, including its Indigenous people, and must be sensitive to gender, language, colour, race and religious beliefs.

2.0 Comprehensive continuum of evidence-informed services and support

The current state points to considerable regional, and often population-specific, variation in the services that are currently available to Manitobans. Recommendations under this Strategic Priority provide guidance for a staged approach to addressing these gaps, beginning with a focus on ensuring that pathways are in place for effective treatment and recovery across all tiers of severity and complexity.

3.0 Seamless delivery of integrated services across sectors, systems and the life span

Recommendations under this Strategic Priority address the current poor coordination of SU/MHA services and the need for more integrated treatment and recovery support. In addition to concrete investments into the system, including transition supports and different models of community housing, enhanced coordination and access will require a significant shift in culture to address the long-standing issues related to the structural and functional separation of SUA and MH services.

4.0 Mental wellness of Manitoba’s children and youth

Rates of complex SUA/MH challenges are high amongst Manitoba’s children and youth – and are in stark contrast to the comparatively low levels of funding for SU/MHA services. The evidence is unequivocal about the common trajectory of MH and SUA challenges, with mental health challenges preceding in early childhood and adolescence. As such, recommendations under this Strategic Priority reflect how investment in children and youth SU/MHA services and supports represents both “treatment” and “prevention” and, ultimately, is an investment in the future health of all Manitobans.

5.0 Mental wellness of Manitoba’s Indigenous peoples

The overall system of SUA/MH services and supports will not improve significantly in terms of access or coordination without a concerted and sustained effort to better meet the needs of the province’s Indigenous people. Recommendations under this Strategic Priority are intended to align with and support the larger healing process facilitated by the Truth and Reconciliation Commission and the National Inquiry into Murdered and Missing Indigenous Women and Girls. The recommendations include a particular focus on the need for more culturally informed services and language supports and on resolving long-standing jurisdictional challenges with respect to SUA/MH services and supports.

6.0 *Healthy and competent mental health and substance use workforce*

The SUA/MH workforce represents one of the greatest assets of the provincial system of services and supports. This Strategic Priority focuses on ensuring that this workforce, which, in large part, will be implementing the details of the Strategic Plan, will be prepared and supported in their work. Recommendations focus on prioritizing workplace wellness and the development of a health human resource strategy that provides guidance for pay equity; the development of standards with respect to caseload qualifications and core competency requirements; and the need to bolster the workforce in key areas such as clinical psychologists, psychiatrists as well as peer-support, recovery coaches and proctors.

To deliver against these six Strategic Priorities, the Manitoba SUA/MH system must also focus on developing its capabilities in several areas referred to herein as “enabling supports” – important areas of focus that are needed to support the system’s efforts to implement this Strategic Plan and achieve the Goal and Vision. Enabling supports in the following four areas are presented in [Section 7.5](#), along with corresponding recommendations.

- Funding and accountability for quality outcomes
- Evidence generation / translation to policy and practice
- Surveillance, monitoring and performance management
- Community engagement and change management

8.0 Summary and Conclusion

In the process of conducting the system review to arrive at this completed Strategic Plan, the Consultant Team conducted a very “deep dive” into the Manitoba SUA/MH system of services. Through several processes, including an extensive document review, the compilation of a host of indicators of community needs, an on-line survey that was extremely well-received by the general public and service providers alike, and a host of interviews, site-visits, consultations, discussions, and validation events, we developed a comprehensive picture of the “Current State” and the “Context” for going forward. During this almost one-year process, we retained a strong focus on issues related to access to, and coordination of, SUA/MH services, while also allowing wider conversations to occur that would inform gap analysis and recommendations—for example, the importance of the social determinants of health and the historical trauma that impacts Manitoba’s Indigenous people to this day.

As we draw the work on this Strategic Plan to a close, we would be remiss not to emphasize the picture of the extremely high level of need and complexity that emerges from our synthesis, as well as critically important regional and population-specific disparities. It is also important to keep focused on the often tragic individual and community stories that underlie this barrage of statistics.

We also identified many challenges related to access and coordination, many of which have been identified previously (e.g., a critical need for more WMS services and ORT; very high rates of suicide or suicide attempts), and others that emerged during the project itself (e.g., increased presentations of crystal methamphetamine-induced psychosis in EDs and the CRC). Such emergent issues remind us that health systems are indeed “complex adaptive systems” that require readiness and adaptability on the part of leadership and the many service providers involved. It’s the nature of the world we all live in. Throughout the project, we were also reminded of the heavy toll that alcohol continues to take on almost all segments of Manitoban society, as well as the challenges accessing treatment in a timely manner, especially for women.

We initiated the system review with a set of key principles that helped guide our review, for example, by structuring the analysis of the massive amount of qualitative data from the on-line survey to highlight needs and gaps in the system according to these principles. These principles were also our starting point for key system design features and they eventually evolved into the core principles and Strategic Priorities of the Strategic Plan itself. Examples, include the focus on population-based planning and the use of the tiered framework; a recovery-oriented system that focuses on wellness, healing and hope; holding strong with a trauma-centred approach, recognizing trauma as the primary root cause of the SUA/MH challenges experiences by so many people; and services that are client/family centred, harm-reduction focused, and welcoming and respectful. These are words that are written into the Strategy with deep intention behind them, as they reflect the voices of the many people contributing their perspective and their stories along the way. They are principles that embody how one works in

this field and how one should turn the Goal, Vision, Strategic Directions and Recommendations into day-to-day reality of implementation.

The journey toward the completion of the Strategic Plan also revealed the historical trajectory of the system, a trajectory that explains in large part the “current state” and the many challenges of access and coordination. It’s a trajectory propelled by multiple “drivers”, many with deep historical roots such as colonization and the residential schools, de-institutionalization, literally thousands of children-in-care with well-documented devastating impacts, increasing availability and diversification of psychoactive substances in the community, and the increasing social complexity of people’s lives. The reduction in stigma and discrimination has also brought more people forward for help, as has the Truth and Reconciliation Commission. All of this is being managed with much the same resource base as was set decades ago during de-institutionalization—*a perfect storm*, if you will. Over time this has led to well-meaning efforts to increase access to services while, at the same time, contributing to considerable protectionist behaviour of many service providers aiming to work within their mandate with the resources they have available. Notwithstanding the many excellent examples of collaboration and partnership that we identified, from the perspective of individuals looking for help for themselves or a loved one, the rules of engagement seemed stacked against them; seemingly designed primarily to “keep you out” rather than “welcome you in”. Certainly, this was strongly reinforced by members of the general public and service providers who responded to the on-line survey. The comprehensive wait time data, assembled for the first time for the purposes of this project, further reinforced the view of the survey respondents that the system is just not able to meet the current level of needs and help-seeking, and, further, that, if you can manage to get into the system through one of the many doorways, it’s another matter entirely to access concrete therapeutic assistance. That’s a longer wait still. Pathways, or stepped services, are challenged by gaps in the continuum or insufficient capacity, for example, community mental health services to step people down from acute psychiatry or PACT teams.

This Strategic Plan is a fresh start forward for the province of Manitoba and sets out a bold agenda of system enhancement. The system is not going to improve overnight – it took a while to get to this current state – nor will it occur without a determined “whole-of-government” and “whole-of-society” effort that recognizes this is indeed “everyone’s business” and, more importantly, everyone has to own a share. Everyone also stands to gain because the business case is so strong, not only for working together, but also for making investments.

In closing, it will be important not to go too fast, but at the same time, to always go forward with confidence and a sense of collaboration and partnership. Manitoba, and all Manitobans, deserve the best. There is a lot at stake, both economically, and in terms of the burden that that SUA/MH challenges are exacting among individuals, families and whole communities. This Strategic Plan offers a concrete way forward to improved mental wellness of all Manitobans.

1.0 Introduction and background

Scope

The Government of Manitoba, as represented by the Minister of Health, Seniors and Active Living, has commissioned a focused, provincial Mental Health and Addiction (MHA) Strategic Plan that will look at ways to improve **access** and **coordination** of mental health and addiction services in the province for Manitobans, including children, youth and adults. In the context of informing improvements with respect to access and coordination, the Strategy must support relevant considerations for service delivery across a range of high need populations and across the spectrum of approaches, including prevention and harm reduction, inter-sectoral partnerships, human resources and knowledge exchange.

Key focus:

Access to services is a complex concept and experts agree that several aspects are relevant. If services are available and in adequate supply, then the opportunity to obtain service exists, and a population may *'have access'* to services. However, access is also related to the *affordability, physical accessibility and acceptability* of services. Furthermore, services available must be relevant and effective if the population is to *'gain access to satisfactory health outcomes'*. The availability of services, and barriers to access, have to be considered in the context of the differing perspectives, health needs and material and cultural settings of diverse groups in society.

Coordination of services can be considered at two inter-related levels. One can consider coordination of individual or family treatment and recovery support (e.g., the work of a service coordinator) as well as coordination of the overall network or system of service providers (e.g., the work of an inter-agency planning committee). A definition that is appropriate for both levels refers to the process by which multiple services and recovery supports, often provided by multiple sectors and service providers, are synchronized to address the needs and strengths of each person and family seeking assistance.

The requirements articulated for carrying out this work and the final Strategic Plan are that it:

- be grounded in evidence-based practice and policy;
- build upon past work, including, but not limited to, the recently completed “Peachey report”; and
- engage multiple stakeholders, including the general public and people/families with lived experience with mental health, substance use and addiction.

A note on terminology

There is a wide range of terminology used to refer to the mental health and substance use and addiction-related challenges that people experience. From a bio-medical perspective, the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition provides diagnostic criteria for defining “mental disorders” and, within the DSM classification system, substance use disorders fall within the broad class of mental disorders. Many people, however, find the DSM-language of “disorders” to be challenging from a recovery perspective, despite its value for planning the bio-medical aspects of treatment and for achieving consistency in definitions for research purposes. Importantly, the DSM-approach does not adequately encompass the fact that many people require and seek advice, treatment and/or recovery support even though they may not meet the formal criteria for a mental disorder. With respect to substance use and addiction specifically, evidence shows conclusively that substance use may be at “harmful” or “hazardous” levels among people who do not meet the formal criteria for DSM-defined disorders and interventions are now tailored to these high risk consumption levels. As a result, many people prefer terminology that is more encompassing such as “substance use and addiction problems” or “mental health problems and illnesses”. This can, however, become quite cumbersome from a readability perspective when using such terms in a report-writing context, especially when referring to mental health, substance use and addictions together in the same phrase. To facilitate readability, the Consulting Team has opted to use an acronym to reflect the language more encompassing than DSM-defined disorders *per se*, but shortened to an acronym, namely SUA/MH to refer to substance use/addictions and mental health problems and illnesses. For example, we will refer to SUA/MH challenges or SUA/MH services and supports. Occasionally, we will use the acronym SUA to refer only to substance use/addiction challenges or services. The exceptions to this general rule will arise when the team is citing original research or other reports that use different terminology, for example, mental illnesses, mental disorders, or substance use disorders, since it’s important to remain true to that level of specificity when citing the work of other authors.

We also provide below a list of acronyms used in the report, again to facilitate readability.

List of Key Acronyms

AA	Alcoholic Anonymous
ABI	Acquired Brain Injury
ACT	Assertive Community Treatment
ADAM	Anxiety Disorders Association of Manitoba
AFM	Addictions Foundation of Manitoba
ALC	Alternate Level of Care
BHF	Behavioural Health Foundation
CBT	Cognitive behaviour Therapy
CCHS	Canadian Community Health Survey
CLDS	Community Living disABILITY Services
CFS	Child and Family Services
CIDI	Composite International Diagnostic Interview
CHP	Clinical Health Psychology
CMHA	Canadian Mental Health Association
CMH	Community Mental Health
COD	Co-occurring Disorders
CODI	Co-occurring Disorders Initiative
CRC	Crisis Response Centre
CSU	Crisis Stabilization Unit
CYMH	Children and Youth Mental Health
DBT	Dialectical behavior therapy
DTFP	Drug Treatment Funding Program
EBPs	Evidence-based Practices
ED	Emergency Department
EIA	Employment and Income Assistance
EIS	Early Intervention Services
EMR	Electronic Medical Record
EMS	Emergency Medical Service
EPPIS	Early Psychosis Prevention and Intervention Service
FACT	Flexible Assertive Community Treatment
FASD	Fetal Alcohol Spectrum Disorder
HCMO	Healthy Child Manitoba Office
HSC	Health Sciences Centre
ICM	Intensive Case Management
IERHA	Interlake- Eastern Regional Health Authority
IPDA	Intoxicated Persons Detention Act
LGBTQQ	Lesbian, Gay, Bisexual, Transgender, Questioning and Queer
LOS	Length of Stay

LRDG	Low-risk Drinking Guidelines
MBC	Management-Based Care
MATC	Manitoba Adolescent Treatment Centre
MCHP	Manitoba Centre for Health Policy
MDAM	Mood Disorders Association of Manitoba
MHSAL	Manitoba Health, Seniors and Active Living
MKO	Manitoba Keewatinowi Okimakanak Inc.
MyHT	My Health Team
MSS	Manitoba Schizophrenia Society
NA	Narcotics Anonymous
NACM	Native Addictions Council of Manitoba
NHRA	Northern Regional Health Authority
NNADAP	National Native Alcohol and Drug Abuse Program
NIHB	Non-Insured Health Benefits
OCDC	Obsessive Compulsive Disorder Centre of Manitoba
ORT	Opioid Replacement Therapy
PACT	Program for Assertive Community Training
PCH	Personal Care Home
PEN	Psychiatric Emergency Nurse
PHIA	Personal Health Information Act
PMH	Prairie Mountain Health
PSNP	Provincial Special Needs Program
PTSD	Post-traumatic Stress Disorder
PX3	Forensic Unit at HSC
RACE	Rapid Access to Consultative Expertise
RAAM	Rapid Access Addiction Medicine
RaY	Resource Assistance for Youth
RHA	Regional Health Authority
SBIRT	Screening, assessment, brief intervention and referral to treatment
SBGH	St. Boniface General Hospital
SH	Shared Health
SH-SS	Southern Health – Santé Sud
SMHC	Selkirk Mental Health Centre
STLR	Stabilization and Transitional Living Residences
UFITT	Urgent Follow up Intensive Treatment Team
WHO_DAS	WHO Disability Assessment Schedule
WMS	Withdrawal Management Service
WRHA	Winnipeg Regional Health Authority
YACI	Youth Addictions Centralized Intake
YASU	Youth Addictions Stabilization Unit
YECSS	Youth Emergency Crisis Stabilization System

2.0 Approach

The VIRGO team, led by Dr. Brian Rush, has implemented a comprehensive quantitative and qualitative approach to an assessment of system-wide strengths and challenges with respect to service access and coordination. The approach involved:

Data indicators: The best and most recent population-level data for Manitoba and its regional health authorities (RHAs) were accessed to establish the nature and level of needs related to SUA/MH, including, where possible, national comparators as well as demographic, health status, social and justice-related indicators.

*Review of evidence*¹: The extant research evidence concerning both system design and effective service-level interventions has been synthesized, including the importance of both evidence-based planning and implementation science to ensure high fidelity and sustainability when applied to the provincial, regional and local context of Manitoba.

Document review: To fully understand previous and present planning context a wide range of documents were submitted by key stakeholders and analysed by the VIRGO team (approximately 275 documents). This included previous strategic planning work at both a provincial and organizational level, and reports of many other special projects and reviews of high relevance to the present work (e.g., analysis on mental health patient flow; review of provincial forensic services). A full listing of the reports reviewed will be provided to the project Logistics Committee under separate cover.

Consultations and discussions: A wide range of key stakeholders internal to government and external in the community, were engaged in interviews or group discussions between April and September 2017, including the representatives of various government departments, RHAs, AFM, contracted service providers, researchers, people living in Indigenous communities, and people/families with lived experience. In many instances, this engagement was undertaken through site visits and tours of programs and facilities. This phase of consultation engaged approximately 350 individuals across multiple sectors (e.g. education, justice, primary care, etc.) and communities. Several individuals and organizations also held complementary consultations with their own stakeholders on behalf of the VIRGO team and submitted a synthesis of this work through briefing notes and reports. Examples include submissions by Block by Block, the Manitoba Harm Reduction Network, the Mood Disorders Association of Manitoba and Manitoba Schizophrenia Society, the Addictions Foundation of Manitoba (AFM) and the provincial team focused on Primary Care Reform. Important written submissions also came from people and families with lived experience such as Westman Families of Addicts in Brandon, and, from many others, written accounts of tragic family loss due to addiction (primarily fentanyl or carfentanil overdose) or mental health (e.g., eating disorder).

¹ Submitted previously by the VIRGO team

Validation events: In October 2017, a series of validation events were held to share highlights of “what we heard” in the above consultations and discussions so as to ensure the emergent findings resonated with the various stakeholder groups. Separate events were held with people and families with lived experience; service providers focusing on adult as well as children and youth services; Indigenous people including Metis and on- and off- reserve First Nations people; and several health system groups including, but not limited to: Health Senior Leadership Council, Shared Health (SH), and the Mental Health and Addictions Branch of Manitoba Health, Seniors and Active Living (MHSAL). Across a total of 10 events, a significant percentage of those originally consulted were re-engaged in this validation process.

In February, 2018 a final round of validation events occurred with smaller groups, but selected from among the same sub-groups of stakeholders. The goal was to get feedback on preliminary strategic priorities and recommendations. A total of seven sessions were held.

On-line survey: Between September 18 to October 13, 2017, an on-line survey was implemented – one version for service providers and another for the general public. Details of the survey methodology and sample representativeness are provided in [Section 6.2.1](#). A total of 3803 people responded (1723 service providers and 2080 members of the general public) to a series of structured questions about the province’s SUA/MH services², for example, about accessing services, perceived quality, and appropriateness of services. An opportunity was also given for open-ended, qualitative feedback, with a sub-set of questions asking specifically about strengths and challenges specific to service access and coordination for Manitoba’s Indigenous populations. The very high participation rate, much of which occurred within the first few days of launching the survey, is a testament to the extremely high interest in SUA/MH in Manitoba, and the opportunity to help shape a new provincial Strategy.

Data request: A comprehensive package of quantitative information about, for example, service capacity and utilization, wait times, and occupancy rates, was requested from the RHAs, Selkirk Mental Health Centre (SMHC), Eden Mental Health Centre, Manitoba Adolescent Treatment Centre (MATC), AFM and a host of publicly funded SUA/MH agencies. This also involved undertaking an exhaustive “system mapping” exercise according to key functions and services of a SUA/MH system based on a National Needs-Based Planning Model.

As part of the Consultant Team’s comprehensive data request to the many key stakeholders and service providers relevant to this Strategic Planning process, a template was provided for each organization to use in noting the services that they provide and offering a brief description of these services. The service categories used in the template are shown in Appendix A. To complement this structured system description, the data request also asked for information on wait times, occupancy levels, length of stay, other indicators of service access and transitions. Many aspects of the data request were significantly challenged by the variability in the

² Survey respondents could respond to questions either for mental health services, substance use services, or both. They could also choose to respond for particular age groups.

collection of many of these service delivery indicators across the participating organizations. Lastly, the total financial resource allocation for SUA/MH services in Manitoba was compiled from information made available through MHSAL, and requested from selected other government sources (e.g., Manitoba Healthy Child Office (MHCO); Manitoba Justice). A separate data request to the provincial RHA's also asked for information on trends in budgetary increases and reductions over the past five years and few other financial details such as investments in training and education.

Information on current levels of service utilization, obtained through the data request, was compiled and compared to estimated levels of need in the community, for both adults and children and youth. Details of this aspect of the project are provided in [Section 6.3.3](#).

Advisory and project management processes: The VIRGO team gave regular updates to the MHSAL Project Logistics Committee and presentations to the Project Reference Group, the latter being a group of key stakeholders and leaders offering ongoing advice on the process of this review and interpretation of findings. (See Appendix B for Reference Group membership).

This final report is organized around the following sections:

1. Past and present contextual factors that are important for understanding the current system as well as results of this review and implications for future system enhancement (i.e., the [CONTEXT](#));
2. The need for investing in mental health and substance use/addiction in Manitoba (i.e. the [NEED](#));
3. The key characteristics of a well-balanced, well-organized treatment and support system that contribute to improved access and coordination (i.e., the [GOALS of SYSTEM ENHANCEMENT](#)); and
4. System description based on existing documentation and a system mapping exercise, feedback from key stakeholders, and quantitative service delivery indicators (i.e., [CURRENT STATE](#));
5. Strategic priorities and recommendations (i.e., [FUTURE STATE](#))

3.0 The CONTEXT: Recognizing and responding to the need for investment in SUA/MH

3.1 International and national context

It is important to monitor national and international trends since they help inform the current planning context by offering comparators on key indicators relevant for considerations of access and coordination as well as insights into new evidence-informed solutions.

A decade ago the Surgeon General of the United States stated that *“there is no health without mental health”* and many experts have since concurred that *“there is no mental health without health.”* Millennia ago the Romans said much the same thing, *“Sound mind, sound body”*, thereby concluding that mind and body are inextricably linked.

Research now shows conclusively that, regardless of age, neglecting one’s mental health is bad for physical health, and vice versa. For example, if you have a chronic physical illness such as diabetes or heart disease and you suffer from depression or an anxiety disorder, you are at considerably higher risk for disability and premature death. Depression and anxiety disorders often express themselves through physical symptoms: stomach problems, headaches, backaches, sleeplessness, fatigue, weight loss, or obesity. People in the early or mid-stages of dementia, such as Alzheimer’s Disease, are likely to also be depressed and/or anxious, and these co-occurring mental health problems reduce already compromised cognitive functions. If you suffer from a long term, severe mental illness, your life expectancy is at least 10 and up to 30 years less than that of the general population, largely due to poor health.

The mantra *“no health without mental health”* has resonated globally for some time now and the World Health Organization (WHO) has been a particularly important champion for the message that mental health is an integral and essential component of health. The WHO constitution states: *“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”*

An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities. Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.

Key messaging from the WHO goes on to state that:

“Mental health and well-being are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. On this basis,

the promotion, protection and restoration of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world”³.

As in all parts of the world, the pain and suffering of Canadian individuals and families experiencing SUA/MH challenges translates into significant costs to society at large, including a significant drain on the public purse.

- **The most recent estimates of the economic burden of mental illness in Canada, including substance use/addiction is well over \$50 billion annually⁴.** Only one of the contributing studies on which this estimate was derived monetized intangible costs and *none* calculated important direct and social spillover cost, for example in the justice system. For SUA alone, the economic burden on services such as health care and law enforcement, and the loss of productivity in the workplace or at home resulting from premature death and disability, tallied to an overall social cost in Canada in 2002 of \$39.8 billion, including tobacco-related costs⁵. **Alcohol accounted for about \$14.6 billion and illegal drugs for about \$8.2 billion for a total of \$22.8 billion, excluding tobacco.** While these estimates for SUA have yet to be updated, adjusting only for inflation will yield a significantly higher total.
- In 2007/8, the costs of providing services and supports to Canadians with SUA/MH was \$14.3 billion; pharmaceutical costs accounting for the highest proportion, followed closely by costs of hospitalization, and provision of community and social services.⁶ Annually, the private sector spent between \$180 and \$300 million on short-term disability benefits and \$135 million on long term benefits. **About 7.2% of government health expenditures in Canada went to SUA/MH services; this percentage ranking well below several other high-income countries.** Expenditures of related social and justice/corrections services are not included in this figure; including these costs would further increase the Canadian funding gap relative to other countries. **In 2016/17, Manitoba only allocated 5.1% of the health budget to SUA/MH services.**

There is also a wide range of statistics providing evidence of the specific health care costs associated with opioid and alcohol use/addiction.

³ <http://www.who.int/mediacentre/factsheets/fs220/en/>

⁴ Wilson, M., & Bradley, L. (2017). *Strengthening the case for investing in Canada’s mental health system: Economic considerations*. Ottawa: Mental Health Commission of Canada.

⁵ Rehm et al. (2006). *The costs of substance abuse in Canada, 2002: Highlights*. Ottawa: Canadian Centre on Substance Abuse.

⁶ Jacobs et al. (2010). *The cost of mental health and substance abuse services in Canada*. Edmonton: Institute of Health Economics.

- Statistics on opioid-related overdoses are of particular interest given the national crisis upon us. Although not yet available for all provinces and territories, the data show **an increase in hospitalizations and emergency room visits for “opioid poisoning” over the past 10 years and particularly in the past 3 years**⁷. While the majority of incidents were reported for people between the ages of 45-64 and 65+, the groups with the fastest growing rates of opioid-related overdose are between two sub-groups analysed separately (15-24 and 25-44).
- While the national opioid crisis is of obvious concern, and with tragic outcomes, the hospitalizations and other health care costs for alcohol have been with us for some time and need to be kept top-of-mind in the current drug crisis (Public Health Agency of Canada, 2016)⁸. Globally, **alcohol was the third leading risk factor for death and disability in 2010, up from 6th in 1990 and accounting for about \$3.3 billion in hospitalization costs annually in Canada**⁹. A recent CIHI report¹⁰ on harms that are 100% attributable to alcohol showed that, in 2015-16, there were more hospitalizations for alcohol than for heart attacks. These numbers do not include a wide range of other alcohol-related hospitalizations such as motor vehicle and other accidents. Direct alcohol hospitalizations were higher for northern regions of the country and among people residing in lower-income neighborhoods.

Many reports also highlight the high rates of SUA/MH among Canadian children and youth, for example:

- A recent CIHI research project¹¹ has shown that, **while the prevalence of mental disorders among children and youth appears to have remained about the same since 2006-7, there has been an increase in Emergency Department (ED) visits and hospitalizations of 53% and 47% respectively**. This is in contrast to an 18% decline in hospitalizations for other conditions and may speak to an increase in severity of SUA/MH and/or an increasing shortage of community resources to meet the need for

⁷ Canadian Institute for Health Information, Canadian Centre on Substance Abuse. (2016). *Hospitalizations and Emergency Department visits due to opioid poisoning in Canada*. Ottawa, CIHI.

⁸ Public Health Agency of Canada (2016). *The Chief Public Health Officer's report on the state of public health in Canada, 2015: Alcohol consumption in Canada*. Ottawa: Public Health Agency of Canada.

⁹ Canadian Centre on Substance Abuse (2007). *Reducing alcohol-related harm in Canada. Towards a culture of moderation*. Ottawa: CCSA.

¹⁰ Canadian Institute for Health Information. (2017). *Alcohol harm in Canada: Examining hospitalizations entirely caused by alcohol and strategies to reduce alcohol harm*. Ottawa: CIHI.

¹¹ Canadian Institute for Health Information (2016). *Child and youth mental health in Canada*. Ottawa: CIHI.

service. One in 12 Canadian youth were dispensed a mood/anxiety or anti-psychotic medication in 2014-15.

- While approximately 11% of Canadian women consume alcohol during pregnancy¹² not all women who drink during pregnancy will give birth to children with Fetal Alcohol Spectrum Disorder (FASD), due to a variety of reasons. Women whose children are diagnosed with FASD are often marginalized, have a history of mental illness, live in poverty, experience substance abuse issues in themselves or in their social network, have a history of physical and sexual abuse, and are subject to the residual effects of historical colonization. Estimates of FASD prevalence vary, but a recent comprehensive study generated a midpoint of 3.6%, which represents a significant financial burden, estimated at \$5.3 billion in Canada alone.
- Published studies involving representative populations of children and adolescents with Intellectual Disabilities/Intellectual and Developmental Disabilities (ID/IDD) have demonstrated a three to four-fold increase in prevalence of co-occurring mental disorders¹³. The new conceptualization of ID/IDD in DSM-5 (and proposed ICD-11) offers an improved, developmentally-informed, approach that can help distinguish co-occurrence of mental disorders with neurodevelopmental disorders, with onset during the developmental period as well as the later onset of other mental disorders.
- Alcohol and drug use among high school students continues to be a concern across Canada. Of particular relevance in Manitoba is the finding that students in rural areas are more likely to report alcohol use, drink five or more drinks at a single sitting, and drive after consuming alcohol. Rural students are also more likely to report driving after using cannabis¹⁴. Implications are evident for access of rural students to prevention and education programs as well as treatment and support resources.

There are also many national indicators of the unique challenges faced by Indigenous people with respect to SUA/MH. It is important to keep in mind that Indigenous health status in

¹² Ruth, C., et al. (October, 2015). *Long-term outcomes of Manitoba's InSight Mentoring Program: A comparative statistical analysis*. Winnipeg, MB. Manitoba Centre for Health Policy.

¹³ Munir, K. (2016). The co-occurrence of mental disorders in children and adolescents with intellectual disability/intellectual developmental disorder. *Current Opinion in Psychiatry*, 29(2), 95-110.

¹⁴ McInnis, M., Young, M.W., & Student Drug Use Surveys Working Group (2015). *Urban and rural student substance use: Technical report*. Ottawa, ON: Canadian Centre on Substance Abuse.

Canada, including mental wellness, must be interpreted in the context of the social determinants of health and historical trauma. Some national highlights include:

- Findings from the First Nations Regional Health Survey (2008-10) indicate that approximately 35% of adults living in First Nations communities did not drink in the past year but, of those who did drink, more than 60% drank heavily. This is significantly higher than other Canadians. Similarly, youth living in First Nations communities were less likely to drink (approximately 60% saying they did not drink in the past year) while, for those youth who did drink, approximately 50% drank heavily¹⁵. In addition, **use and abuse of alcohol and drugs was ranked by First Nations on-reserve as the top challenge for community wellness**. Rates of suicide on First Nations communities are 5 to 6 times that of the general population.
- Results similar to those reported for First Nations communities are reported for First Nations people living off-reserve as well as Métis and Inuit people - among those who do drink, a significant percentage drink heavily and experience many challenges as a result¹⁶. Similarly, they also report poorer health status and more frequent chronic illness as well as significant challenges related to housing and food security.
- Comparative analyses of Inuit people living within their traditional homelands (i.e., Inuit Nunangat) or outside (i.e., other provinces and territories, including Manitoba) show about a 2.5 times greater prevalence of mood disorder diagnosed by a health professional and significantly higher self-reported rates of occasional or regular drinking¹⁷. However, the percentage of people reporting heavy drinking did not differ. Suicide rates among Inuit youth are 11 times the national rate and access to health services, including SUA/MH services, is a major challenge¹⁸. Travel to services available in a small number of regional hubs across the country, including Winnipeg, is the norm with ensuing challenges from many perspectives including the cultural and language difficulties and the lack of follow-up continuity of care.

The call for a systems approach: These are only a few of the statistical highlights that can be brought to bear to illustrate the importance of responding to SUA/MH in the Canadian context.

15 First Nations Information Governance Centre (FNIGC) (2012). *First Nations Regional Health Survey (RHS) 2008/10: National report on adults, youth and children living in First Nations communities*. Ottawa ON: FNIGC.

16 Gionet, L. & Roshanafshar, S. (2013). *Select health indicators of First Nations people living off reserve, Métis and Inuit*. Ottawa, ON: Statistics Canada

¹⁷ Wallace, S. (2014). *Inuit health: selected findings from the 2012 Aboriginal Peoples Survey*. Ottawa ON: Statistics Canada.

¹⁸ Inuit Tapiriit Kanatami (2014). *Social determinants of Inuit health in Canada*. Ottawa ON: Inuit Tapiriit Kanatami.

To reflect the growing concern over the level of need, and the human and economic consequences, important national organizations have articulated the importance of a **broad system response**. The Mental Health Commission of Canada has issued a national mental health strategy¹⁹. In addition, the Canadian Centre on Substance Use and Addiction has called for improving the quality, accessibility, and range of treatment and support options within its National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada²⁰, as well as its National Treatment Strategy²¹ and many subsequent initiatives and reports. Importantly, mental health, including substance use and addiction, has been declared a national priority such that the 2017/18 federal budget confirmed that \$5 billion will be transferred to provincial and territorial governments over the next 10 years to improve access to services²². While experts note the funding gap that will remain, the anticipated allocations offer both an opportunity and a challenge to use any forthcoming resources prudently²³. A recently announced national housing strategy²⁴ also argues for investment opportunities in SUA/MH given their intimate connection with housing and other social determinants.

Investments to increase access and coordination: Deliberations about the optimal investments to enhance mental health and substance use/addiction services, including access and coordination, are fundamentally grounded in two, sometimes competing, goals of health systems – **how to maximize both reach and health outcomes**. Efforts to maximize reach, often articulated as “*narrowing the treatment gap*”, are critically important given the relatively low proportion of people in need of treatment and support who actually seek and receive services of even minimal quality, estimated at about 16.1% for depression²⁵, for example. Investing in

¹⁹ Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada*. Calgary, AB: Mental Health Commission of Canada.

²⁰ Canadian Centre on Substance Abuse (2005). *National framework for action to reduce the harms associated with alcohol and other drugs and substances in Canada*. Ottawa, ON: CCSA

²¹ National Treatment Strategy Working Group. (2008). *A systems approach to substance use in Canada: Recommendations for a National Treatment Strategy*. Ottawa, ON: Canadian Centre on Substance Abuse, National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada

²² Budget, 2017. *Building a strong middle class*. Ottawa: Finance Canada, 2017.

²³ Bartram, M. (2017). Making the most of the federal investment of \$5 billion for mental health. *Canadian Medical Association Journal*, 189(44), E1360-E1363.

²⁴ Canada’s National Housing Strategy. (2017). <https://www.placetocallhome.ca/pdfs/Canada-National-Housing-Strategy.pdf>

²⁵ Thornicroft et al. (2017). Under-treatment of people with major depressive disorder in 21 countries. *The British Journal of Psychiatry*, 210, 119-124.

the supply of SUA/MH services is one critically important strategy to close the treatment gap. That being said, the barriers that people cite regarding access to services are both system-related and personal²⁶. Public education is also required to de-stigmatize mental health and addiction and show the value of seeking assistance. The general public also needs to know the range of services and supports that is available to them and how to access and navigate the system to best meet their needs. Also, to maximize reach, all stakeholders must be open to new, innovative and cost-effective ways of delivering services such as the use of Internet and mobile technology, and new treatment models focused on harm reduction, self-management, brief intervention, peer support and group-based treatments.

The second goal of treatment systems, optimizing health outcomes, serves as a critical counterpoint to efforts to maximize reach since reach should not sacrifice service quality and diminish the individual or family experience of accessing and receiving services. A focus on outcomes also calls for the use of validated screening, assessment and outcome monitoring tools and processes to ensure an optimal, individual match along the treatment continuum and in a stepped approach context. Measurement-based Care (MBC) can be defined as the practice of basing treatment on client information collected throughout the treatment process itself and is now considered a core component of numerous evidence-based practices²⁷.

Also, critically important is the recent shift in perspective concerning the actual outcomes to be achieved, outcomes now articulated from a “recovery” perspective. This perspective seeks to optimize quality of life and overall well-being while also working towards improvements of symptoms associated with mental illness and addiction^{28,29}. This emergent recovery paradigm is also serving as an important bridge between the too often disparate worlds of mental health and substance use/addiction since “recovery” has been a key element of addiction work for decades. In addition, “recovery” resonates so closely with the fundamental tenets of harm reduction; for example, the emphasis on choice, valuing a variety of substance use-related outcomes, and seeing abstinence itself as but one step towards improved quality of life and wellness.

²⁶ Sunderland, A., & Findlay, L.C. (2013). Perceived need for mental health care in Canada: Results from the 2012 Canadian Community Health Survey – Mental Health. Statistics Canada, Catalogue NO. 82-003-X. *Health Reports*, 24(9), 3-9.

²⁷ Scott, K., & Lewis, C.C. (2015) Using measurement-based care to enhance any treatment. *Cognitive and behavioral practice*, 22, 49-59.

²⁸ Jacob, K.S. (2015). Recovery model of mental illness: A complementary approach to psychiatric care. *Indian Journal of Psychological Medicine*, 37(2), 117–119.

²⁹ Davidson L. (2009). Recovery, self-management and the expert patient: Changing the culture of mental health from a UK perspective. *Journal of Mental Health*, 14, 25–35.

This focus on recovery and wellness is also serving as an important bridge between mainstream and Indigenous mental health and substance use/addiction services and system planning since the concept of individual and community wellness is so firmly grounded in Indigenous culture and world view³⁰.

At a national level, long-standing Indigenous issues have also been declared a priority; evident in part by the work of the Truth and Reconciliation Commission as well as the National Inquiry into Missing and Murdered Indigenous Women and Girls. SUA/MH are significant public health concerns for some Indigenous populations in Canada because many face major challenges that affect their health and wellbeing such as high unemployment, poverty, poor access to education, poor housing, being located far from health services, the displacement of Indigenous language and culture, and social and economic marginalization. In order to address health issues, there is a need to understand how Indigenous social determinants of health affect and contribute to a holistic view of health. For Indigenous populations, historical and cultural factors play a particularly important role. New funding opportunities such as those under the umbrella of Jordan's Principle, which is aimed at improving access to critically important children's services, offer important opportunities for breaking through perceived and real jurisdictional issues, with a common focus on healing. The development of provincial and territorial mental health and addiction strategic plans, such as the present case in Manitoba, also present important opportunities as they allow for sharing of key values, ideas, approaches and lessons learned.

3.1.1 Business case for government investment in mental health and substance use/addiction

International research is unequivocal in its support for the effectiveness of SUA/MH services, including services for people experiencing co-occurring challenges. It is also critically important for policy makers and funders to recognize that not only are services and supports effective, but they also **return that investment in significant financial terms, thereby making an exceptionally strong business case for investment in treatment and support.**

With respect to SUA, the strongest evidence comes from comprehensive cost-benefit studies which show a significant return on investment, the largest portion being a reduction in justice-related costs. In one of the best studies, on average, the economic benefits of treatment in

³⁰ Health Canada, the Assembly of First Nations (2015). *First Nations Mental Wellness Continuum Framework*. Ottawa ON: Health Canada and the Assembly of First Nations.

relation to costs yielded a greater than 7:1 ratio of benefits to costs³¹. These benefits were primarily because of reduced costs of crime and increased employment earnings. Studies undertaken from a broader mental health frame, which often includes substance use and addiction, also show unequivocally that mental health services are a good investment (see a recent report commissioned by the Mental Health Commission of Canada for a summary of international and Canadian research³²). Salient examples include a Canadian cost-benefit analysis that estimated \$2 in savings to society for every \$1 invested in expanding Medicare coverage of psychological services³³. A recent report from the Conference Board of Canada estimated that the Canadian economy could grow up to \$49.5 billion annually if all employed Canadians with depression and anxiety received good treatment³⁴. In the UK, the key motivation for expanding access to psychological therapy, as Ontario is now doing with significant increase in access to Cognitive Behavioural Therapy, was the projected economic cost recovery³⁵.

Provision of adequate housing and housing-related supports, now considered a core component of the SUA/MH service continuum, also provides an economic return on the financial investment. For example, the evaluation of Manitoba's At Home/Chez Soi project not only showed a wide range of positive outcomes but also illustrated the economic benefits such that \$17,527 in savings were accrued for high need participants and \$4,838 for moderate need participants. Savings came primarily from reduced hospitalization and use of other health care services as well as reduced frequency of incarceration³⁶. **In short, the business case for investing in mental health and substance use/addiction services has been settled. Experts agree it's now a matter of government taking that seriously and acting on the evidence** ^{14, 20}.

Another view on the business case for investment in mental health and substance use/addiction concerns the so-called “**cost-of-doing nothing**” argument. Reviewing the above synthesis of costs to society attributable to SUA/MH crystallizes this convincing argument since

³¹ Ettner et al., (2006). Benefit–Cost in the California Treatment Outcome Project: Does substance abuse treatment “Pay for Itself”? *Health Services Research*, 41(1), 192–213.

³² Wilson, M., & Bradley, L. (2017). *Strengthening the case for investing in Canada's mental health system: Economic considerations*. Ottawa: Mental Health Commission of Canada.

³³ Vasiliadis et al., (2017). Assessing the costs and benefits of insuring psychological services as part of Medicare for depression in Canada. *Psychiatric Services*, 68(9), 899-906.

³⁴ Sutherland, G., & Stonebridge, C. (2016). *Healthy brains at work: Estimating the impact of workplace mental health benefits and programs*. Ottawa: The Conference Board of Canada.

³⁵ Layard et al., (2007). Cost-benefit of psychological therapy. *National Institute Economic Review*, 202, 90-98.

³⁶ Distasio, J., Sareen, J, & Isaak, C. (2014). *At Home/Chez Soi Project: Winnipeg Final report*. Calgary Alberta, Mental Health Commission of Canada.

these costs are rapidly accruing year-by-year with no sign of abating without concerted action on the part of government. In Manitoba, the cost-of-doing-nothing can include the cost of extended stays in acute and chronic care psychiatric beds due to lack of community housing options; avoidable Medevac events from the north to the south with a return trip following assessment and stabilization but no ongoing treatment and support plan; the cost of RCMP transport of involuntary persons to psychiatric inpatient units and other police involvement with serious SUA/MH challenges such as waiting in ED's for cases to be processed, including the gap in community policing services while officers are so engaged; or the cost of sending people out-of-province for treatment (e.g., eating disorders, post-traumatic stress disorder, substance use/addiction). With respect to Manitoba's out-of-province treatment, the costs now exceed an average cost per patient of \$67,682 or about an annual total of \$1 million with marked increases in recent years³⁷.

Where does prevention fit? It is axiomatic that efforts to improve access to and coordination of services are intimately linked to “upstream” efforts to prevent SUA/MH challenges. There are two important linkages; the first being the intuitive relationship between annual incidence (i.e., the number of emergent new cases in need of assistance each year) and the capacity of the system to respond (i.e. demand capacity). If these two factors are not in reasonable balance, this translates into waiting times and other costly systemic outcomes such as the use of less than optimal services for addressing needs. This includes the avoidable use of emergency department and crisis services. Secondly, the link to prevention and public health promotion is bolstered by evidence that shows that the health of the community, reflected in community recovery capital such as employment, social support and other social determinants, is critically important for achieving and sustaining recovery³⁸.

In this vein, it is important to note that prevention efforts also pay off, and, as such, also become a wise investment to improve access to, and coordination of, SUA/MH services. While it is challenging to show the long-term economic payoff of investments made today, especially for children and youth, a wide range of prevention and health promotion activities for many mental health problems and illnesses as well as substance use/addiction have been modelled for economic benefits and strongly support the proposition that government investment in

³⁷ Durksen, A. (2017). Environmental scan of residential treatment centres for mental health and addictions. Report prepared for Mental health and Addictions Branch, Manitoba health, Seniors and Active Living.

³⁸ Hennessey, E. (2017). Recovery capital. A systematic review of the literature. *Addiction Research and Therapy*, 25 (5), 349-360.

prevention will accrue future cost savings^{39, 40}. Tragic outcomes such as suicide are also preventable⁴¹, especially through a broad public health approach. Another important perspective on future, preventable costs comes from longitudinal research which unequivocally shows that mental health problems and illnesses in childhood not only predict many subsequent problems in adolescence but also problematic substance use and addictions⁴². This advances a convincing argument that investment in mental health treatment and support for children and youth is, in fact, an effective prevention strategy not only for mental health problems and illnesses as an adult, but also for substance use and addiction.

Recent exciting developments in epigenetics and neuroscience have also shown the impact on the developing brain of toxic stress through “adverse childhood events” or ACEs. ACEs impact on brain development predict a host of subsequent physical health challenges as well as SUA/MH⁴³. Interestingly, the impact of ACEs on future substance use and addiction challenges is partially mediated by the onset of mood and anxiety disorders⁴⁴; again, suggesting that mental health treatment at an early age can be preventive for substance use and addiction at a later age. This research and a host of other studies have provided an exciting foundation for multi-sectoral programs and policies aimed at preventing SUA/MH (see, for example, the emergent provincially-focused prevention program in Alberta through the Family Wellness Initiative⁴⁵).

3.2 Manitoba planning context

As noted earlier, this work on a new and focussed provincial strategy to improve access to, and coordination of, SUA/MH services builds upon a lot of relevant work done over the past decade and earlier.

³⁹ Knapp et al., (2011) *Mental health promotion and mental illness prevention: The economic case*. Department of Health London, UK. http://eprints.lse.ac.uk/32311/1/Knapp_et_al__MHPP_The_Economic_Case.pdf

⁴⁰ O'Connell, M.E., Boat, T, & Warner K.E.(Eds). (2009). *National Research Council (US) and Institute of Medicine (US) Committee on the prevention of mental disorders and substance abuse among children, youth, and young adults: Research advances and promising interventions*. Washington (DC). National Academies Press (US).

⁴¹ Zalsman et al. (2016). Suicide prevention strategies revisited: 10-year systematic review. *The Lancet – Psychiatry*, 3(7), 646-659.

⁴² Copeland et al., (2013). Diagnostic transitions from childhood to adolescence to early adulthood. *Journal of Child Psychology and Psychiatry*, 54(7), 791–799.

⁴³ Chapman et al. (2007). Adverse childhood events as risk factors for negative mental health outcomes. *Psychiatric Annals*, 37(5), 359-364.

⁴⁴ Douglas, K. et al. (2008). Adverse childhood events as risk factors for substance dependence: Partial mediation by mood and anxiety disorders. *Addictive Behaviours*, 35(1), 7–13.

⁴⁵ <http://www.albertafamilywellness.org>

Key documents reviewed: In order to understand the implications of previous and current planning and system development activities, and with the focus on access and coordination of services in mind, a wide range of important documents were reviewed by the VIRGO team⁴⁶. Notable documents have included, but are not limited to:

- Speech from the Throne at the opening of the third session of the 41st Manitoba Legislature, November 21, 2017.
- A Federal Government *Common Statement of Principles on Shared Health Priorities* with across Federal/Provincial/Territorial jurisdictions.
- The Peachey report, *Provincial Clinical and Preventive Services Planning for Manitoba*
- *Rising to the Challenge*, Manitoba's provincial mental health strategy launched in 2011, and follow-up documents describing achievement of implementation milestones. Also reviewed was a 2009 document reporting the results of provincial consultations to assist in the development of the strategy.
- A 2013 report from the Provincial Medical Leadership Council Working Group on Mental Health
- The Winnipeg Regional Health Authority (WRHA) *Regional Mental Health Program 10-year Strategic Plan: 2016-2026* as well as an earlier 2012 review of the WRHA Adult Mental Health Program
- The 2016-2021 Strategic Plan for Selkirk Mental Health Centre (SMHC) as well as an earlier report on the consultation strategy and environmental scan and a subsequent report on accreditation which referenced key milestones.
- The 2008 statement of addictions services priorities under *Breaking the Chains of Addiction: Manitoba's Five Point Strategic Plan* and a background consultant's report on the Assessment of Manitoba's Addictions Services.
- The 2002 consensus document on the emergent *Co-Occurring Mental Health and Substance Use Disorders Initiative (CODI)*; a 10-year retrospective review and analysis of CODI; and a recent report from SMHC on an environmental scan relating to internal co-occurring disorder and substance use services.
- Background documents and discussion papers relating to the new Shared Health, a key component of Manitoba's health system transformation.
- The 2015 review of the WRHA Forensic Mental Health Services (which also reviews collaboration with SMHC forensic services) and a brief status report of subsequent planning efforts between the two parties.

⁴⁶ These previous reports are distinct from the special written submissions made by various stakeholders to the VIRGO team and which have been analysed in concert with the other elements of the consultation process (e.g., site visits, interviews and focus groups). Also, several other documents will be used to inform the gap analysis in the next report.

- A keynote presentation on the overall planning context by Dr. Jitender Sareen, Medical Director of Psychiatry for WRHA Mental Health Program and Head of the Department of Psychiatry at the University of Manitoba.
- A 2011 review of the Seven Oaks General Hospital Geriatric Unit.
- A 2013 report from the Manitoba Centre for Health Policy (MCHP): *The 2013 RHA Indicators Atlas*
- Draft of Executive Summary of the MCHP report Mental Illness among Adult Manitobans, due for release in 2018 and provided to the VIRGO consultant team for purposes of this report.
- WRHA statistical analysis reported in early 2018 entitled: *Walk-in Visits with Positive Response to “Amphetamine Type Stimulants” on Mental Health Physical Health Screening Form.*
- WRHA report in 2017 entitled: *Methamphetamine Presentations to WRHA Emergency Departments.*
- Outline of the preliminary plans of the MHSAL for a response to the crystal meth crisis
- A backgrounder document and summary report to the Provincial Lobby Day 2018, *Mental Health Matters*, submitted by the Student Advocacy Committee, University of Manitoba.
- A private submission concerning the impact of 2009 legislative changes concerning the regulation of the profession of social work in Manitoba and the impact of that legislation not only on social workers but also other professionals working in SUA/MH.
- A report by the MCHP on *Health and Social Outcomes Associated with Alcohol Use in Manitoba* with permission to use selected statistics prior to its official release.
- *Wait Times Reduction Task Force: Final Report*, submitted to the Minister of Health Seniors and Active Living, November 2017.
- *A Phase 1 Process Evaluation of My Health Team (MyHT)* and a recent Primary Care Policy Directive providing information about the current plans for improving Manitoba’s primary care sector as well as a submission of feedback for consideration by the consultant team on Primary Care in Manitoba.
- A compilation of material related to Indigenous peoples including The Strategic Plan of the Manitoba Inuit Association 2017-18; a report of a Mental Health Forum, January 2017 at Elkhorn resort; the evaluation report on the Safety and Efficacy of Gatekeeper Training in First Nations/Métis Communities for the Prevention of Suicide; a Health Canada *Guide for First Nations to Access Non-Insured Benefits*; and important national-level frameworks and documents of high relevance to the Manitoba situation including the *First Nations Mental Wellness Continuum Framework*, and the Report of the Truth and Reconciliation Committee and the Interim Report on the National Inquiry into Missing and Murdered Indigenous Women and Girls.
- A range of materials focused on child and youth related work including Manitoba’s *2015 Child and Youth Mental Health Strategy* and a 2016 Healthy Child Committee of Cabinet

report on the *Public Consultations on Child and Youth Mental Health*; the 2015-16 Annual Report of the MATC and its Operational Plan 2017-2018; several reports of Healthy Child Manitoba Office (HCMO) initiatives (e.g., evaluation report of Healthy Babies program; The Early Development Instrument (EDI) report 2014-15 and the report on the province-wide pilot and evaluation of PAX); The Educational Outcomes of Children in Care in Manitoba (2015), *Long-Term Outcomes of Manitoba's Insight Mentoring Program: A Comparative Statistical Analysis* (2015); other reports by the Manitoba Centre for Health Policy (e.g., *The Mental Health of Manitoba's Children* (2016) and *How are Manitoba's Children Doing* (2012)); a summary of previous and current work underway with respect to children and youth with complex needs under the umbrella of the Children with Complex Needs Policy Committee; evaluation of the provincial START project (Selkirk Team for At-risk Teens); materials from the Canadian Mental Health Association such as the *Living Life to the Full for Youth Evaluation* and a proposal for a comprehensive model for youth mental health in Manitoba; highlights of submissions made to the Federal government Status of Women Committee on Eating Disorders.

- A variety of population-specific reports including a WRHA consultation report on Post-Partum Mental Health issues; the report by the Manitoba Brain Injury Association *"We've Been There, We Can Help"*; and a provincial environmental scan on Community Living disABILITY Services regarding clients accessing mental health services.
- A recent report from the Gang Action Agency Network (GAIN): *Bridging the Gaps: Solutions to Winnipeg Gangs*.
- Recent reports concerning refugee mental health work, including a joint WRHA and Immigrant and Refugee Partners' report on *"Optimizing the Mental Health and Emotional Wellbeing of Immigrants and Refugees in Winnipeg: A Conceptual Framework"*; and a Provincial Refugee Mental Health Action Plan Summary of Work: 2015-2016.
- A set of key reports commissioned by the WRHA concerning peer support in the follow-up to mental health presentations in emergency departments and crisis settings; and highlights of an environmental scan conducted by the Manitoba Recovery Champions Committee of recovery-oriented practices in the province;
- Several reports from the Addiction Foundation of Manitoba including but by no means limited to program evaluation reports: Auricular Acupuncture Pilot Project (2011); Centralized Intake and Performance Measurement Project (2013); Winnipeg Drug Court Evaluation (2016); Manitoba Key Worker Program (2016); the Starfish Program (2016); AFM Impaired Driving program (2017); Manitoba Drug Treatment Funding Program (DTFP, 2017); a 2014 evaluation of the James Toal Centre Intensive Programs; practice guidelines (e.g., recommendations for improving opioid replacement services; screening and assessment tools and process); and results of client follow-up outcomes.

- Other relevant addictions-related work including systems evaluation reports from Behavioural Health Foundation; the report from Dr. David Brown on the Alcohol Screening and Brief Intervention DTFP project 2015-16; and a consultant's assessment of the adult addiction services in 2007-08.
- A host of special project reports and documents from the five Regional Health Authorities, including but by no means limited to Annual Reports of the respective Mental Health Programs, including MATC, Eden Health Care Services, and SMHC ; other material about mental health residential care facility services and cost pressures; the WRHA pilot project of a Home-based Mental Health Program; special analyses of patient flow and clinical pathways; a report on the Mental Health Resource Nurse Program in Prairie Mountain Health (PMH); reports and reference sheets about PMH's Supportive Transition Evaluation and Planning Service (MH-STEP).

It is not the intention in this review to undertake a detailed, qualitative document analysis of this extensive list of planning and system development reports. Rather, the review of this material focused on distilling important contextual themes to help interpret the new information being collected in this review and potentially triangulating with key findings.

Important historical context: In 1992/93, the Government of Manitoba introduced a mental health strategy focussed on the severe and persistently mentally ill. Subsequent initiatives involved the closure of the Brandon Mental Health Centre, re-direction of resources to community programs in the local health regions, the establishment of Selkirk Mental Health Centre as a provincial centre to address the needs of the long term mentally ill population, and the transfer of patients to community resources. Changes also entailed the transfer of the Psychiatric Nursing Program (SMHC/hospital based) to establish an education program within the Brandon University. As a result of these reforms, the regional delivery system focussed on initiatives and programs for the severe and long term mentally ill population.

Subsequently in 2011, the Mental Health and Spiritual Health Care Branch of the Department of Health led the development of a multi-stakeholder mental health plan, known as '*Rising to the Challenge*', which resulted in a series of activities to support the existing system in the delivery of services. During this time as well, emphasis was placed on the development of a multi-stakeholder prevention plan. Simultaneously, Healthy Child Manitoba Office (HCMO) led the development of a multi-year planning process and initiative development, to prevent FASD and support families who were affected by FASD.

In 2015, HCMO undertook an expansive community dialogue addressing child and youth mental health. It resulted in the document: *What We Heard: Public Consultations on Child and Youth Mental Health*, released fall 2016.

Importantly, these developments in the mental health sector did not include addiction programming and services in the mandate. However, in 2003, addiction program and service alignment did occur between mental health and addictions, albeit on a limited and periodic basis. The focus was addressing co-occurring issues, known as the Co-Occurring Disorder Initiative (CODI), beginning in 2003⁴⁷. This initiative drew in staff from both addictions and mental health services. A provincial policy supported this work, however it was compromised by the inability to maintain a provincial coordinator role and other competing priorities and direction in both systems. While examples of the training remain available, the initiative has not been renewed for several years.

Addiction services and programming was addressed in 2008, and with the assistance of an independent consultant, a plan produced by the Government described as “*Breaking the Chains of Addictions: Manitoba’s Five Point Strategic Plan*” was introduced. That plan had five pillars related to addiction programming. This was subsequently enhanced by federal resources introduced in Manitoba, under the Drug Treatment Funding Program, which brought addiction providers together for system improvements. This initiative was introduced in 2007 by the federal government, under the National Anti-Drug Strategy.

Recent Developments: There are significant planning and development activities that provide information into the current review as well as serve as important context for determining and prioritizing implications and recommendations.

The 2016 Throne Speech that opened the Manitoba parliament under Premier Brian Pallister highlighted the need to improve accessibility to, and coordination of, mental health and addiction services and set the stage for a provincial review and new Strategic Plan. This commitment coincided closely with the release of the Peachey report which identified SUA/MH services as one of 10 priorities for health system enhancement in context of a broader provincial Clinical and Preventive Services Plan. The November 2017 Throne Speech again highlighted the need for improvements in the province’s SUA/MH services among other broad goals, including efforts to improve the province’s fiscal balance sheet and economy, enact broader health system enhancements and take significant strides towards child care and early years education.

Considerable stakeholder consultation underpinned the development of the 2008 *Breaking the Chains* addiction strategy, the 2011 *Rising to the Challenge* and the 2015 *Provincial Child and Youth Mental Health Strategy*. **An important difference in the current system review, and highlighted in the brief historical overview and several other documents reviewed, is the coverage and inclusion of BOTH mental health and substance use/addiction going forward.**

⁴⁷ Winnipeg Regional Health Authority, Addictions Foundation of Manitoba, Manitoba Health. (2002). *Co-Occurring Mental Health and Substance Use Disorders Initiative (Winnipeg Region) consensus document*. Winnipeg, MB: WRHA.

While this has increased the span and depth of consultation and analysis for this review, particularly with respect to SUA, there is also considerable stakeholder input to build upon. The same can be said for the project's goal to cover the entire life span – children and youth, adults and older adults.

Shared national priority. The November 2016 Summit, led by Health Canada, with provincial involvement, focussed on the growing problem of opioid use and harms, including tragic and untimely deaths. In 2017, the Federal Government also initiated legislation to initiate the legalization of cannabis (marijuana) for recreational use. Both these developments impacted the growing awareness in the country of addiction and the need for treatment services.

Importantly, Federal/Provincial/Territorial Ministers of Health have also established Shared Health Priorities which reflect a common interest in SUA/MH⁴⁸. The ensuing *Common Statement of Principles* cites confirmation of the 2017 budget for \$11 billion over 10 years in new federal funds to improve access to SUA/MH services, as well as to home and community care. It noted the commitment to develop bilateral agreements with each province and territory to outline how federal funds for mental health and addiction services, as well as home and community care, would be used consistent with the Principles. It also committed to work collaboratively to develop a focused set of common indicators to enable Canadians to assess progress on SUA/MH and home and community care. All this being said, concerns are expressed in some quarters about the targeted nature of the funding commitment and considerable work remains to determine how each Canadian jurisdiction will utilize any funding opportunities that do materialize⁴⁹.

The Manitoba system is evolving: Health systems are always in flux and the context surrounding the present review is no different. Indeed, the recently released report on ED wait times⁵⁰ emphasized the nature of health systems, including emergency services, as operating within “complex adaptive systems”. Such systems, “similar to a human body that has multiple organ systems, each of which has a specific function, but that also interacts with all other systems interdependently” (p. ix, Executive Summary). The implication is that solutions that appear to be reasonable in the moment either fail to work or often have unintended consequences in another part of the system. This is especially true when the problem being addressed is a so-called “wicked problem”; a term that certainly applies to the increasing levels of SUA/MH and the system's capacity to respond. This calls for careful and collaborative planning and, as

⁴⁸ <https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/principles-shared-health-priorities.html>

⁴⁹ Canadian Press (August 28, 2016). Advocates: Canada's mental health system needs funding. file:///C:/Users/Brian/Downloads/MFP_Email-%20(4).pdf

⁵⁰ Wait Times Reduction Task Force (November, 2017). *Wait Times Reduction Task Force: Final Report*, submitted to the Minister of Health Seniors and Active Living.

further noted in the ED report, *“an overarching governance structure to ensure the system has clear authority, shared goals, effective decision-making and accountability”* (p. x, Executive Summaries section).

There are many parallels to the discussion of complex adaptive systems with respect to improving ED wait times and the current focus on improving access and coordination to the province’s SUA/MH services. Examples of the evolving provincial landscape include:

- Important developments at the overall governance level that emerged during the course of the review with respect to the creation of the new Provincial Health Organization, also known as Shared Health (SH).
- New federal funding opportunities resulting in new services being developed, for example, the expanded crisis services for First Nations communities delivered by Manitoba Keewatinowi Okimakanak (MKO) and MATC’s newly awarded program to expand child and youth mental health services to all 63 First Nations communities under Jordan’s Principle, with a focus on telehealth and other supports.
- On top of the already concerning and often tragic opioid overdose crisis in the province, the rapidly growing use of, and complex consequences associated with, crystal methamphetamine has swamped EDs and crisis response services in the WRHA and elsewhere. This has led recently to the opening of six new beds to better support these individuals and also improve safety for the health care professionals responding to their needs. Other options are currently being considered.
- Major service changes have also been announced (e.g., clinical consolidation has closed some emergency departments in the WRHA) and a government funding delay has held many positions vacant at SMHC resulting in closure of “open” beds. AFM has recently announced a review of its residential services; efforts continue to evolve for the addition of another PACT team within the WRHA; and PMH has made significant progress towards the development of a new community withdrawal management service in Brandon.
- While many opportunities and decisions have been awaiting the new Strategy (e.g., considerations for a specialized substance use/addiction treatment unit at SMHC; a proposal for a coordinated, ongoing plan for new refugee and immigrant mental health services) this evolving landscape is the reality of a comprehensive planning exercise such as this. The review of past work does, however, highlight that, while investments have been made in recent years to enhance the province’s SUA/MH system, these enhancements have been made by multiple stakeholders in the system and without the benefit of a provincial plan. This reminds us again of the need to consider future enhancement in the context of complex adaptive systems and the need for strong collaboration and governance. There is high interest in the development of this new provincial Strategy to not only fit into the new health system transformation but also to present a unifying vision and identify priorities to guide future investments.

Evolving demographics: The various documents reviewed have placed an important focus on high need groups that, in part, reflect demographic trends (e.g., the aging population and capacity for treating dementia; the comparatively younger age of the province's Indigenous population; the high number of children in care; significantly higher rates of youth suicide in northern and Indigenous communities; the growing population of newcomers including refugees) and in part the evolving complexity of needs (e.g., highly complex children and youth, co-occurring disorders, opioid addiction and overdose). The present review with its focus on access and coordination will no doubt bring more focus to high need sub-populations and draw attention to the need for collaborative solutions focused on health equity and reducing disparities.

Indigenous people: The high percentage of Indigenous people in Manitoba is critically important context for past and current planning efforts, as is their history of colonization and historical trauma, and ongoing challenges with respect to social determinants of health. Foundational opportunities for healing provided by the Truth and Reconciliation Commission and the National Inquiry into Murdered and Missing Indigenous Women and Girls are critically important for building engagement and trust in provincial health services planning, including the development of the current Strategy. Jurisdictional issues between provincial and federal authorities, including First Nations Inuit Health Branch (FNIHB) of Health Canada, with respect to First Nations people in Manitoba received considerable attention in previous work as well as the present review. The previous work does, however, provides a lot of building blocks for addressing jurisdictional issues (e.g., highlighting the need for community- and culture-based solutions) and the new Strategy can offer suggestions for continuing to move this work forward.

Significant research and evaluation capacity: There is very strong research and evaluation capacity in Manitoba that has contributed high quality work to peer-reviewed literature, as well as previous planning and evaluation processes. Examples include research conducted under the auspices of the University of Manitoba (e.g., Manitoba Centre for Health Policy, Health Sciences Centre, other Departments); Healthy Child Manitoba Office; Manitoba Health, Seniors and Active Living and other government departments, Addictions Foundation of Manitoba, and some private research consultants such as Dr. David Brown. There are also several examples of excellent collaborative research and evaluation across these focal points of expertise. The Knowledge Exchange Centre within AFM is exceptionally strong and a unique focus for this important function in the province. The implementation of the Strategy can draw upon these focal points of excellence and collaborative relationships to help coalesce and prioritize research topics within a provincial research and evaluation plan to fill gaps in knowledge, support measurement of results, and assistance in operational planning.

The strength of the province in the areas of research and evaluation, notwithstanding, the nature and scope of much of the work to date suggests the need for more focus on translating research and evaluation findings into practice. Ensuring better application of results can benefit from implementation science to help not only with planning for potential scale up at the outset,

but also with ensuring implementation fidelity and sustainability. Along these same lines, there seems to be a tendency for provincial, regional and organizational strategic planning processes, in general extremely comprehensive and well-done, to lack concerted follow-up action. This trend will need to be guarded against in the context of the present Mental Health and Addiction Strategy, for example with proactive processes, change management, performance metrics and clear lines of accountability.

Challenged information systems: Further, as strong as the research and evaluation capacity is in the province, another cross-cutting theme in previous work is the challenge presented by multiple, region-specific, and often rudimentary, information systems that impede not only the transfer of important information for safe and effective treatment and recovery support but also opportunities for system-wide planning, research, evaluation and performance measurement.

Disparity between needs and system capacity: A common theme cutting across, and indeed driving, much of the previous work is the disparity between the nature and scope of Manitobans' needs and the capacity of the system to respond. This disparity, and the results of analyses of system bottlenecks and transition "hot spots" has drawn significant attention to the prevailing concerns with access and coordination of services, and potential solutions (e.g., increasing service supply, the need for collaborative services, as well as innovation in service delivery, and the role of public education in reduction of stigma and discrimination). The focus of the present review on access and coordination of services has been well placed with consistently expressed concerns regarding difficulties to access services and confusion around system navigation.

A wealth of information is provided that informs specific gaps in the service, to be summarized in subsequent sections of the report and reflected in recommendations. A theme does emerge about the relative imbalance in past investment and current state with respect to acute, hospital-based services compared to less resourced community-based services. A similar theme emerged for the relative investment in adult versus children and youth services; the latter being viewed in some reporting as the "*poor cousin of the poor cousin*".

Importance of prevention and health promotion: The need for a strong focus on prevention and public health promotion, within the context of making improvements to the delivery of SUA/MH services, is an important theme cutting across much of the previous work reviewed. Many reports support a broad, population-based approach that integrates planning across the full spectrum of severity and individual needs, including people who might benefit from early intervention and/or self-management approaches. Peachey is perhaps the strongest advocate for prevention, calling for an 8% allocation of all health resources to prevention, combined with a cross-governmental priority for "health in all policies". Although it may be a challenge to maintain this focus on prevention and health promotion in the ensuing Strategy, given it's directed focus on service access and coordination, it will be important to give due attention to upstream work since it is so closely related to need and help-seeking. This call for a cross-

government, multi-sectoral response to SUA/MH resonates strongly given the close links to social and justice-related issues as well as public health and safety.

Integration of mental health and addiction: An important cross-cutting theme in much of the past work has been the call for better integration of SUA/MH services in the province; the Peachey report being the most recent and salient example. All other Canadian jurisdictions have taken significant steps toward such integration noting for example, that this is a process that can take some time and which is easier to put into practice at the administrative and policy level that “on-the-ground” so to speak in integrated clinical services. But much progress has been made in most of the Canadian provinces and territories and many lessons learned, such as the need to pay special attention to “protect” the SUA sector during the integration process with the much larger and often more medically-oriented mental health sector.

In past planning work in Manitoba, and selected examples of current work, SUA is noticeably, including missed opportunities for research and evaluation due to separate service delivery and information systems. Other examples include the unclear place of SUA in anticipated work with respect to peer support in crisis/ED settings and the province’s MyHTs, to cite only two examples. The present review affords the first opportunity in Manitoba for a Strategy that will support closer integration of SUA/MH services not only at the client-provider interface but also within system planning, accountability and performance measurement efforts.

Importance of collaboration: Many planning efforts have shared the aspirations of system enhancement through improved collaboration beyond the SUA/MH sectors to specifically include closer collaboration with primary care. This collaboration is also seen as a two-way street, with primary care also needing support for an expanded role; for example, through rapid access to psychiatric consultation such as through the Rapid Access to Consultative Expertise (RACE) program. This emphasis on collaboration with primary care is consistent with national and international trends, to the extent that BOTH mental health and substance use/addiction are included in these collaborative efforts, and with a strong team-based, multi-disciplinary focus.

Importance of recovery orientation: The previous work reviewed acknowledges, and is highly supportive of, shifting the province’s mental health services to be “recovery” oriented and, in a manner that complements the past bio-medical focus on outcomes to be achieved (essentially symptom reduction and/or illness management). This focus on recovery has played out in many ways, including advancing a stronger role for peer support and recommendations to improve supports for families. As the concept of recovery has played a strong role in Manitoba’s addiction services, the inclusion of both mental health and substance use/addiction in the present review affords an important opportunity to advance a mutual understanding of recovery, and thereby facilitate closer integration of services including those provided by peers.

Importance of evidence-based interventions: There is a broad consensus in the host of material reviewed that, at the level of bio-medical, psychosocial and spiritual/cultural interventions,

there should be a strong focus on evidence-informed approaches within the new Strategy. There is also an emerging consensus on the need for interventions to be trauma-informed, co-occurring disorder capable and client-centred, and to include a strong role for the family and other loved ones. Aside from these areas of agreement, concerns were often voiced about the overall quality of services and the processes by which an intervention is declared “evidence-based” and chosen for implementation. This has several obvious implications for the current review.

Workforce challenges: Workforce issues are reflected in many key documents reviewed, whether it be an assessment of workforce shortages such as psychologists, psychiatrists or psychiatric nurses; a call for new components to the workforce such as peer support workers and recovery coaches; or issues related to role clarification, competencies and clinical supervision vis a vis core services. Important legislative changes in 2009 concerning the regulation of social workers in the province has impacted the ability of other professionals to be similarly regulated and which is having some unforeseen negative consequences within the Manitoba workforce for SUA/MH. While the present review was not expected to yield a detailed workforce strategy it can build upon this previous work and contribute to provincial workforce planning.

4.0 The NEED: What is the burden of SUA/MH on Manitobans?

Population trends are important given the link between SUA/MH to many demographic characteristics such as age and Indigenous status as well as many health, social disparity and justice-related indicators.

4.1 Population trends

Manitoba is home to about 1.3 million people with population growth occurring at a moderate pace relative to the rest of Canada; a 15% increase (or 200,000 people) is expected in the next 10 years. As in other Canadian jurisdictions, the population is expected to grow more rapidly among the older age categories, although there is significant regional variation around this. For example, the Northern region has a much higher percentage of children, and a much lower percentage of older adults than Manitoba overall. The Northern region's population will also increase faster among children and adolescents.

The best current estimate of the size of Manitoba's Indigenous population, including First Nations on-and off-reserve, Inuit and Métis is about 18%⁵¹. This is the highest percentage among provincial and territorial jurisdictions in Canada. There is, of course, wide regional variation in this percentage, for example, 11% of Winnipeg, 25% of Portage la Prairie and just over 50% of Thompson. As noted above, there are also important age differences such that, in contrast to non-Indigenous Manitobans, a much higher percentage of Indigenous people are children and youth. Importantly, due to higher early mortality rates, only a small percentage of First Nations in Manitoba are over the age of 65 (4% compared to the rest of the province (about 15%)).

Manitoba has long been a home for newcomers to Canada. Immigration numbers hit a peak in 2016 compared to the previous decade due largely to the spike in the category of "resettled refugees and protected persons". This includes the recent incoming newcomers and refugees from countries such as Syria, Afghanistan and several parts of Africa⁵². Currently, immigrants to Canada, including those with non-permanent status, comprise about 18% of the Manitoban

⁵¹ Statistics Canada (2016). Aboriginal Peoples Highlight Tables. (<http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/abo-aut/index-eng.cfm>). Estimates such as these are challenged by earlier exclusion of incompletely enumerated Indigenous communities, variability in the individual interpretation of Indigenous ancestry, as well as factors related to self-disclosure.

population⁵³. Of these, 7.2% are non-permanent residents and 27.8% arrived between 2011 and 2016. Of new permanent residents between 2008 and 2012, 9.4% or 24,071 were classified as refugees; with Manitoba having the distinction of receiving the highest number of refugees per capita in Canada. The most recent statistics continue to bear this out. Welcome Place welcomed 1758 refugee claimants between January and October 2017, 975 individuals and 783 families. There were 1125 asylum seekers, including a significant number of RCMP interceptions. Of all national RCMP interceptions, Manitoba accounted for about 6%, but second behind only Quebec in this category. The large majority of claimants (about 80%) stated an intention to stay in the province. While the majority of newcomers, including refugees, are living in Winnipeg, many are also being settled outside of Winnipeg, for example, in the Southern region. Mental health needs of refugees are well-documented globally⁵⁴ and in Canada specifically⁵⁵. While new surveillance systems are needed and currently being put in place to monitor these needs in Manitoba, available data from Aurora show 27% with probable Post Traumatic Stress Disorder (PTSD), 25% with symptoms of depression and 27% with symptoms of anxiety disorder. These are all significantly higher than suggested by general population data.

4.2 Health-related indicators

Some important health status indicators cited in the Peachey report include:

- Despite Manitoba having one of the highest provincial per capita health expenditure rates in Canada, and the highest percentage of overall budget spent on health services, Manitobans actually experience poorer health outcomes.
- Manitobans' perceptions of their health, self-reported by those aged 12 and over, are lower than the national average.
- Manitobans have the highest rate of premature mortality, avoidable mortality and potential years of life lost.
- Emergency department visits have increased across the province by nearly 17% over the period in the decade leading up to 2011/12, a large proportion of which are related to SUA/MH.

⁵³ Statistics Canada (2016). Immigration and Ethnocultural Diversity Highlight Tables. 2016. <http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hltfst/imm/index-eng.cfm>

⁵⁴ Bogic, M., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: A systematic literature review. *BMC International Health and Human Rights*, 15, 29. 9

⁵⁵ Beiser, M., & Feng, H. (2017). Predictors of positive mental health among refugees: Results from Canada's General Social Survey. *Transcultural Psychiatry*, 54(5-6), 675-695.

- Regional variation across a wide range of health (and social) indicators is significant, in particular, increasing disparities as the analysis moves north through the province. Examples include lower life expectancy and higher levels of chronic disease, including diabetes mellitus.

A 2013 MCHP report⁵⁶ provides a variety of health indicators at the provincial and RHA level and shows that the health of Manitobans has improved significantly over time, despite the aging of the population. Life expectancy increased, and death rates decreased. Potential years of life lost and premature mortality rates also decreased, indicating that fewer people died before the age of 75 years. The results also show that the diagnosed prevalence of many diseases and health conditions decreased, including respiratory diseases, ischemic heart disease, osteoporosis, and congestive heart failure. Heart attack and stroke rates also decreased. There was, however, NO substantial change in the diagnosed prevalence of a number of common mental health conditions, including substance use disorders. This has been re-confirmed in a recent update of this work⁵⁷.

The recently released study of ED wait times highlighted that, compared to the rest of Canada, the time to wait for a physician assessment in Manitoba's EDs was close to double that of Canada generally – 5.5 hours compared to 3.0 hours (see [Footnote #50](#) above). With the exception of Health Sciences Centre Pediatrics Emergency, all WRHA EDs exceeded the norm for similar sized Canadian comparators every year between the study period of 2010-11 and 2016-17. There is a close relationship between ED wait times and access to acute care beds – with 30% of acute care beds occupied by patients requiring an alternate level of care, this flows backwards to an increased wait in the ED. This was also viewed as a challenge for patients presenting with SUA/MH. Importantly, although the percentage of ED visits related directly to SUA/MH was reported as “low” (about 3% of all visits), these visits were said to account for a disproportionate use of time and resources due in large part to their complexity of presentation, including security concerns, and limited options for resolution. Further, a range of equity considerations were identified and of particular importance for this report, including the relationship between access to health care and ED wait times and social determinants such as income and living in a rural or remote area and being an indigenous person. The critical need for more rapid access to psychiatry for those presenting to the ED with a SUA/MH challenge was also highlighted.

The risk of HIV is closely connected to needle sharing for injection drug use and, therefore, the rate of HIV in the population is an important public health indicator relevant for SUA. In

⁵⁶ Fransoo R, Martens P, The Need To Know Team, Prior H, Burchill C. et al. (2013). *The 2013 RHA Indicators Atlas*. Winnipeg, MB. Manitoba Centre for Health Policy.

⁵⁷ Draft of Executive Summary of the MCHP report Mental Illness among Adult Manitobans, due for release in 2018 and provided to the VIRGO consultant team for purposes of this report.

Manitoba, a total of 105 new HIV cases (8.0 cases per 100,000 population) were reported based on laboratory-positive HIV antibody tests between January 1st and December 31st, 2015, representing a 21% increase over 2014 but a 13% decrease from the peak in 2010. In terms of Public Health Agency of Canada's **90-90-90** targets, at the end of 2014:

- a total of 2,117 people was living with HIV and **79%** were aware of their HIV status;
- **77%** of people knew their HIV status and were receiving treatment and
- **86%** of people on HIV treatment had a suppressed viral load that was unlikely to be transmitted to others.

4.3 Social and justice indicators

Recent analysis of high users of health care among patients of Manitoba's current My Health Teams highlighted the significant overlap between mental health and physical health conditions, defined as "medical complexity". That being said, a significant number of high users of health services also fell into the category of "social complexity", defined with indicators of income assistance, education, justice, social housing, CFS involvement. Importantly, social complexity was more closely related to mental health complexity than physical health complexity.

This combination of medical/psychiatric and social complexity is also well-illustrated by two other projects:

- (1) The pilot testing of a Home-based Mental Health Program for patients discharged from inpatient psychiatry in the WRHA resulted in a profile of a small number of clients and found multiple mental diagnoses were the norm, including about half with substance use disorders; over 75% had medical diagnoses (cardiac bone/joint, and other); and the majority lived alone with few or unstable family supports, were not employed and experienced a range of other basic needs, such as access to food.
- (2) Another study evaluated the HCMO program INSIGHT, a mentoring program to support women who use alcohol during pregnancy and showed that, among 236 participants: 59.1% initiated alcohol use at 13 years of age or younger, 45.9% started binge drinking in the same age range, 81% drank alcohol during pregnancy, 77% reported a history of depression, 49% said they needed mental health services, 57% reported a need for social housing, 25% needed domestic violence services, and 25% were not receiving income assistance despite no reported employment income.

Following the Canadian trend, Manitoba's rate of child and family poverty was marginally lower in 2015 compared to 2014 but remained the highest of any province - well above the national

rate⁵⁸. Manitoba moved from the province with the third highest child poverty rate in 1989 to the highest rate in 2015. Other highlights include:

- 62% of children who were living in single parent families in Manitoba lived in poverty, one-third of children under the age of 6, and more than 1 in 3.5 of all Manitoban children – an estimated 85,110 children.
- The rate of food bank use for children is almost double the national rate, second only to Newfoundland and Labrador.
- Manitoba has the highest rate of Indigenous child poverty, both on reserve (76%) and off reserve (39%).

Manitoba matches the national rate for single parent families (about 4.6% of households) but with important regional variation (e.g., 6.7% in the Northern region and 2.3% in the Southern region).

The number of children in care in Manitoba in 2014 was 10,293, representing the highest rate of children in care in Canadian provinces. Whereas about 26% of Manitoba's children are Indigenous, they represent close to 90% of children in care. Categorized by Indigenous group, 12.1% of First Nations children, 3.3% of Métis children, and 13.7% of Inuit children in Manitoba were in care at some point during 2006. To summarize another way, in 2006, 22 out of every 100 First Nations children—or one of every four to five—in Manitoba was taken into care at some point before 15 years of age. The comparable percentage for non-Indigenous children was two out of every 100. A wide range of educational outcomes has been shown to be associated with the experience of being a child in care.

Homelessness statistics are available for Winnipeg (1400 people in 2015); Thompson (126 people in 2015/16 and Brandon (146 people in 2016). In Winnipeg and Thompson between 35-40% were considered "Absolute Homeless" (i.e., unsheltered or living in emergency shelter), the remainder being "Provisionally Accommodated" (i.e., living in another's home, transitional housing, institution, motel). In Brandon, the "Provisionally Accommodated" category accounted for 80% of the homeless. In Winnipeg, about 25% were youth under the age of 30. In Thompson, about 95% were Indigenous.

The rate of homicide among Manitobans was almost twice the national average in 2016 and ranked second after Saskatchewan, among Canadian provinces.

On an average day in 2015/16, there were 40,147 adults in custody, representing the highest rate of incarceration among Canadian provinces.

⁵⁸ Manitoba Child and Family Report Card. (2017) (retrieved Dec.20. 2017 from https://campaign2000.ca/wp-content/uploads/2017/11/2017-MB_ChildFamilyPovReportCard_FINAL.pdf)

4.4 Mental health and substance use/addiction indicators

4.4.1 Adults⁵⁹

According to the *2012 Canadian Community Health Survey – Mental Health*, about 27% of Manitobans 15 years of age and over report having abused or been dependent on alcohol in their lifetime, which is much higher than the Canadian average of 18.1%. Past year rates are also much higher at 5.1% compared to 3.2%.

Analyses of the data from the survey for purposes of this review⁶⁰ show Manitoba standing out as having the highest prevalence of people meeting criteria for mental and substance use disorders compared to all other provinces. Adjusting for population differences in sex, age, income, race, education, and marital status, Manitoba ranked first for past-year Major Depressive Disorder, Generalized Anxiety Disorder, and Alcohol Use Disorder, the latter being twice that of Ontario rates, for example. Manitoba ranked second behind Nova Scotia in prevalence of Substance Use Disorder (i.e., other than alcohol) and only for Bipolar Disorder did it occupy lower than second place across the country. Manitoba was also ranked first among all provinces in terms of reported suicidal ideation and suicidal plans.

A new report from the MCHP⁶¹ shows the 15.1% of females and 20.6% of males 15 years of age and over in Manitoba exceeded the recommended daily limits for alcohol consumption. Long term trends indicate that Manitoba drinkers tend to binge drink more than the Canadian average with levels of binge drinking⁶² decreasing for men but increasing for women over the last 10 years⁶³. Among other important findings for system planning, it was also noted in the recent MCHP report that those with a diagnosis of alcohol use disorder used significantly more health services but, interestingly, were most likely to seek help for a mental health or behavioural disorder.

In 2013, the MCHP calculated the diagnosed⁶⁴ prevalence of mental and substance use disorders with data pooled across 2002/03 to 2006/07, and compared to data pooled across 2007/08 to 2011/12. Across these two different time periods, the prevalence of mood and anxiety disorders was found to be stable over time. The prevalence of mood and anxiety

⁵⁹ Some of these “adult” studies included a small number of children over the age of 10 and/or adolescents.

⁶⁰ Sareen, J. & Turner, S. (2017, personal communication)

⁶¹ Nickel et al. (in press). Health and social outcomes associated with alcohol use in Manitoba. Manitoba Centre for Health Policy, Winnipeg, Manitoba.

⁶² Binge drinking refers to five or more drinks in one sitting for men and four or more drinks in one sitting for women.

⁶³ Young et al., (2014). *Background: Alcohol use in Manitoba*. Unpublished manuscript: Canadian Centre on Substance Abuse. Cited in Manitoba’s Strategy to Reduce Alcohol-related Harm.

⁶⁴ Diagnosed prevalence is calculated from administrative health data based on the number of people given a diagnosis by physician when accessing hospital or office-based physician services.

disorders was significantly related to income in urban areas, with much higher prevalence among residents of lower income areas. Similarly, rates of substance use disorders were also shown to be stable over time but with significant regional and sub-regional variation. For example, the prevalence of substance use disorder was strongly associated with area-level income in both urban and rural areas, with the lowest income areas having considerably higher rates.

The prevalence of dementia in Manitoba was also shown to be stable over time at 10.6% of the population aged 55 and older. Rates in all regions reflected this stability. There was substantial variation across the districts of rural regions from just over 4% to over 20% as well as large variation among Winnipeg neighborhood cluster from 5% to over 19%.

A recent study by the MCHP (see [Footnote #57](#) above) has provided updated information on the diagnostic prevalence of mental disorders among adults in Manitoba using data across 2010/11 to 2014/15. These data are important since they not only contribute up-to-date information on the current level of need, they will also serve as important population-level, baseline data for measuring impact of the present Mental Health and Addiction Strategy. Highlights include:

- Overall the prevalence of diagnosed mood and anxiety disorders was 23.2% and substance use disorders, 5.9%, these disorders, being first and second most common, respectively. The 5-year diagnostic prevalence of dementia also remained unchanged.
- Many of the results above were also re-affirmed, for example, the strong relationship between being diagnosed with a mental disorder, including substance use disorder, and living in a rural and/or low-income area of the province.
- Gender differences also held such that men were more likely to be diagnosed with a substance use or psychotic disorder and women with mood and anxiety disorders.
- Compared to the province as a whole, a higher prevalence of mental illness, including substance use disorders was found among those living in personal care homes, those receiving social assistance, those living in social housing and those involved in the justice system as accused or victims.
- With respect to suicide and attempted suicide, the population rates did not change since an earlier MCHP 2004 report. Men had higher rates of completed suicide and women higher rates of hospitalization for suicide attempts than men, although the gender differences varied by age group. Suicide deaths were highest in Interlake-Eastern and Northern regions and rates of hospitalizations due to suicide attempt were highest in Prairie Mountain and Northern.

- People with mental illness, including substance use disorders, used more health care services than those with no mental illness even after controlling for age, gender, income, and medical conditions. Notably, the rates of long-stay hospitalizations (lasting between 15 to 365 days) were three times higher for people with mood and anxiety disorders and three times higher for those who had attempted suicide compared to those with no diagnosed mental illness. The same pattern was found for the frequency of emergency department visits.
- There was a strong relationship between being accused of a crime or being a victim of a crime and being diagnosed with a mental illness. For people diagnosed with a substance use disorder this amounted to a four-fold difference compared to those without a diagnosis of mental illness.
- With respect to children, as many as 16% of the cohort born between 1980-811-1984/85 were diagnosed with a mental illness, including substance use disorder before they turned 18 years of age. Further being diagnosed with a mental disorder in childhood/adolescence increased the risk of being diagnosed with the same disorder in adulthood.

Importantly, being diagnosed with a mental disorder in childhood/adolescence increased the risk of a wide range of adverse experiences as an adult, including suicidal behaviours, not graduating from high school, justice system involvement, receiving income assistance, and living in social housing.

An important recent study comparing several provinces on mental health performance indicators differentiated Manitoba from other provinces in several ways:

- Access to the same family physician was higher among people diagnosed with a mental disorder or addiction, especially for young adults.
- Too often people access ER for mental health support because they have not received help elsewhere. Therefore, treatment contact for mental health and/or addiction in an ER prior to being seen by another health care provider in the previous two years is an indicator of that gap in service – Manitoba was lowest, indicating the poorest performance compared to the other jurisdictions.
- Rates of suicide attempts that led to hospitalization were higher for Manitoba across all age groups
- Rates of completed suicides were higher for Manitoba across all age groups

The total number and rate of suicides per population in Manitoba remained consistent between 2010 to 2015. For much of this period the rate was equal to Alberta and just trailing

Saskatchewan in the ranking of provinces⁶⁵. As noted above, Manitoba ranked first among all provinces in terms of reported suicidal ideation and suicidal plans in data reported in the 2012 Canadian Community Health Survey – Mental Health. In terms of regional variation, the rate of suicide is about twice as high in the Northern region and about 1.5 times in Interlake/Eastern region compared to the province as a whole.

While impaired driving collisions have declined significantly over the past decade, in 2012 Manitoba Public Insurance reported nearly 2000 alcohol-related criminal code convictions. Young drivers, especially those between 16-24 years of age are highly represented in alcohol-related convictions. On average 29 Manitobans are killed and 39 seriously injured annually in motor vehicle collisions involving impaired drivers. In 2013, Manitoba ranked 4th among provinces in the percent of fatal crashes on public roads involving alcohol alone and 3rd involving drugs alone⁶⁶.

One in 10 Manitoba drivers who participated in voluntary roadside surveys in the fall of 2016 tested positive for drugs other than alcohol⁶⁷. 53% of these drivers tested positive for cannabis, 31% for cocaine, 12% for opioids and 2% each for benzodiazepines and amphetamines/methamphetamines. 22% tested positive for more than one drug.

The use of crystal methamphetamine appears to be on the rise in Manitoba with a concomitant increase in challenging presentations to ED and crisis response services. For example, walk-in presentations to the CRC in Winnipeg that were coded positive for “Amphetamine Type Stimulants”, increased from about 20 per month in 2013 to 80-90 per month currently and since mid-2016⁶⁸. Similarly, across all WRHA Emergency Departments, visit counts with mention of methamphetamine use in the triage notes increased from about 10 per month in 2013 to about 190 per month to the end of 2017, with no sign in the statistics of levelling off⁶⁹. Other documentation as well as the reported feedback from ED staff highlighted the significant resource demand in supporting these patients as well as significant security, restraint, and safety issues often involving Winnipeg police.

⁶⁵ The Conference Board of Canada. (2017). <http://www.conferenceboard.ca/hcp/provincial/health/suicide.aspx>

⁶⁶ <http://madd.ca/pages/wp-content/uploads/2015/03/The-presence-of-alcohol-and-or-other-drugs-in-motor-vehicle-fatalities-by-jurisdiction.pdf>

⁶⁷ Manitoba Public Insurance News Release. (March 15, 2017). <https://www.mpi.mb.ca/en/Newsroom/News-Releases/Pages/nr2017march15.aspx>

⁶⁸ WRHA statistical analysis reported in early 2018 entitled: Walk in visits with positive Response to “Amphetamine Type Stimulants” on Mental Health Physical Health Screening Form.

⁶⁹ WRHA report in 2017 entitled: Methamphetamine Presentations to WRHA Emergency Departments

With respect to opioid use and related consequences, the challenges across multiple sectors are increasing dramatically⁷⁰:

- In Manitoba, prescription opioid dispensation steadily increased from 86.7 per 10,000 persons in 2007/2008 fiscal year to 143.2 per 10,000 persons in 2016/2017 fiscal year.
- During the first quarter of 2017 in Manitoba, compared to the same time period in 2016, apparent opioid-related deaths increased by 88%. The largest increase was noted for apparent fentanyl-related deaths, where 40% of these deaths had the fentanyl analog carfentanil present. Synthetic opioid (including fentanyl) poisoning hospitalizations also increased by 117%.
- Comparing the first and second quarters of 2017 indicated that the naloxone kits used in overdose events increased by 40%; among these events, fentanyl and carfentanil were the common substances used. The use of crystal meth in overdose events also doubled.
- In Manitoba, the number of illegal fentanyl-related opioids identified or tracked by Drug Analysis Service of Health Canada increased 27 times from 2012 to 2016; approximately half of the illegal fentanyl-related opioids were carfentanil during the first half of 2017.

Between January and March 2017, 29 sites were registered in the province for naloxone distribution (23 operating and 6 preparing to distribute) and 258 kits were distributed. About 1 in 10 were used in overdose events, the majority in Winnipeg. This may underestimate the number of potentially fatal overdoses due to concerns about reporting use of the kits.

Infants born to chronic opioid users are frequently born with a dependency to such drugs and experience withdrawal after the opioids cease to be administered following birth. The resulting effects are known as neonatal abstinence syndrome (NAS), which has a negative impact on vital bodily functions such as feeding, elimination and sleeping. Recent Canadian estimates suggest that 0.3% of infants are born with NAS. In 2015-16, there were 102 hospitalizations for neonatal abstinence syndrome in Manitoba ranking it fifth among provinces based on live births in the same period.

From November 2016 to March 2017, 101 people who accessed sterile injection drug use supplies at provincial harm reduction sites anonymously reported in the Street Connection Survey that the drug most commonly injected was crystal meth (50%). This is a marked increase from the drug-use trends captured in 2006 I-Track (Public Health Agency of Canada [PHAC]) for

⁷⁰ EpiReport: Epidemiology & Surveillance, Active Living, Indigenous Relations, Population and Public Health, Manitoba Health, Seniors and Active Living (November, 2017). *Surveillance of opioid misuse and overdose in Manitoba*, April 1 to June 30, 2017.

Winnipeg, in which only 6% of respondents reported the use of crystal meth by injection. Increased access to harm reduction supplies was the most valued service needed, followed by supervised consumption and increased access to addiction services.

With respect to needle/syringe distribution dynamics, during the 2016/17 fiscal year there were more than 1.5 million needles distributed in Manitoba (WRHA 1.36 million; 145,000 all other RHAs) and these numbers have more than tripled in the past three years alone. Tracking data suggest these numbers are continuing to increase.

A gambling prevalence study conducted by AFM in 2006 revealed 1.4% of Manitobans are problem gamblers, 2.1 % are at moderate risk, and 1.4% are at-risk gamblers.

Compared to other provinces, there are three times the number of forensic patients per incarcerated population in Manitoba but 50% fewer forensic beds⁷¹. A 2006 national overview of forensic services showed Manitoba to rank second lowest among Canadian provinces in total forensic staff to patient ratio, lowest in beds per 10,000 adults charged and 3rd lowest in beds per “*mentally disordered accused persons*”⁷².

4.4.2 Children and youth

A Manitoba study of the mental health of children aged 6 to 19 found that about 1 in 7, or about 14%, received a diagnosis of a mental disorder by a physician between 2009 and 2013 – a rate almost double that of the national average - and even higher in Winnipeg’s inner-city neighbourhoods and the province’s north⁷³. *This Manitoba rate of mental illness among children and youth is 1 in 7, higher than diabetes or asthma.*

Among teens, the rates of suicide, substance-use disorders and psychotic disorders followed a similar pattern. The actual rates could be higher because the study only counted children seen by a physician and not those treated by a psychologist, school counsellor or other health care professional. The report found poverty to be the common link since a poor family can be under financial and emotional stress, live in inadequate housing and have a hard time getting nutritious food.

⁷¹ Cited in the minutes of the Provincial Forensic Services Planning Meeting, May 13, 2016.

⁷² Livingston, J.D. (2006). A statistical survey of Canadian forensic mental health inpatient programs. *Healthcare Quarterly*, 9(2), 56-61.

⁷³ Chartier M, Brownell M, MacWilliam L, Valdivia J, Nie Y, et al. (2016). *The mental health of Manitoba’s children*. Winnipeg, MB. Manitoba Centre for Health Policy.

Children and youth with complex needs face multiple, interconnected challenges which require formal collaboration among departments/agencies, including but not limited to, child welfare, schools through sporadic attendance, the youth justice system, emergency departments dealing with violent injuries, and mental health/addiction crisis and treatment services. The most complex children and youth are estimated to cost the province between \$1-\$2 million per child per year and with limited positive life outcomes.

The 2012 Manitoba Youth Health Survey includes students in grades 7 to 12 and reported that:

- 45% of students (35% of male and 53% of female students) reported feeling so sad or hopeless in the past year that they stopped doing some usual activities for a while;
- 37% (34% of male and 41% of female students) report being bullied, taunted or ridiculed in the past year;
- 20% of students reported consuming 5 or more drinks within a couple of hours in the past month
- 17% of students (18% of male and 17% of female students) report using an illegal, prescription, or over-the-counter drug for the purposes of getting high in the past month

4.4.3 Indigenous populations

A recent Opaskwayak Cree Nation community needs assessment project⁷⁴ conducted focus groups and surveyed students in grades 7 to 12 (n=152) and community adults (n=603). Some highlights of the report included:

- Among adults, alcohol and drug use ranked second behind diabetes as the most important health concern for the community
- A key theme in community focus groups was alcohol use during pregnancy
- Over 50% of adults were diagnosed with depression (27.1%) or anxiety (23.1%) and 10% felt like they wanted to hurt themselves always or sometimes. Despite these high rates, few community members were accessing mental health counselling services.
- 31% reported not feeling safe in their community.
- 10% of adults felt like they wanted to hurt themselves all or sometimes.
- 1 in 6 adult community members (17.1%) had received substance abuse treatment. Of these people, 20.7% were mandated by Child and Family Services or the Department of Justice and 54.9% had to leave their community.
- Among youth:
 - 70.5% reported being physically threatened or injured;

⁷⁴ Presentation provided to VIRGO team by OCN during site visit.

- 71.4% reported being bullied or being picked on through social media;
- 63.8% reported that someone had said something bad about their race or culture; and
- 31% reported not feeling safe in their community.
- While alcohol use was not frequent, youth tended to binge when they drank alcohol. A quarter of youth (25%) said they had five or more drinks within a couple of hours at least once in the past month.

A 2009 survey conducted by the Manitoba Metis Federation identified higher rates of depression, anxiety, and substance use disorders and other associated complications compared to other Manitobans⁷⁵.

⁷⁵ Sanguins, J. et al. (2013). *Depression, anxiety disorders and related health care utilization in the Manitoba Métis population*. Manitoba Metis Association- Health and Wellness Department.

4.5 Summary of needs and the implications

This needs profile is critically important for marshalling the motivation to deal with the challenges being presented, and make recommendations for improving access and coordination.

Needs are extremely high: Manitoba stands out as the highest or very high on almost all SUA/MH need indicators, including those related to health, social and justice-related factors. Behind the “numbers” lies a huge financial drain on the province as well as an often tragic physical and emotional drain on communities, families and individual Manitobans. Taken together, the overall level of need clearly signals a call to action.

Needs are costly: A convincing economic argument is made that responding to this call for action with wise, evidence-informed investments will return a positive economic benefit. Comparing to other provinces, and in the context of the high need relative to other jurisdictions, Manitoba’s lower contribution to SUA/MH, further reinforces the call to action from a “business case” perspective. Doing nothing is itself costly. That being said, investment is not only about financial resources, but also includes streamlining processes for maximum value.

Needs are population and region/community specific: The regional variability in a large number of need indicators, and the association with specific disparity indicators and populations, including Manitoba’s Indigenous people, is critically important in the pursuit of solutions. This includes respecting cultural differences, understanding and acknowledging well-established root causes, and working diligently to deal with real and perceived jurisdictional issues.

Needs are evolving: Several indicators highlight the evolving nature of needs, for example, the trends in population growth and diversity, SUA, and increasing complexity of individual and community situations. Implications for system enhancement include the need for flexibility in key features of the system such as finely tuned surveillance systems, keeping services grounded as closely as possible in the community to be constantly on top of emergent trends, and embedding services in organizations that are adaptable and nimble.

Needs begin early in childhood: The data are compelling with respect to the impact of early childhood mental illnesses, and that treatment can help prevent SUA/MH in later years.

Needs are complex: Needs for SUA/MH services are intertwined in very complex ways with physical health, social and justice-related challenges. This has implications not only for ensuring person-centered, individualized treatment and support, but also calls for a “whole-system, multi-sectoral response”. A provincial governance model must support this multi-sectoral response and also facilitate a truly bio-psycho-social-spiritual/cultural approach, including the solutions for access and coordination specifically.

Needs do have solutions: As complex as this situation clearly is at a provincial, regional and local level, the evidence exists for responding effectively. The purpose of the Strategy is to articulate and prioritize these solutions in a way that facilitates improved access and coordination.

5.0 The GOAL – Key aspirational features of SUA/MH treatment and support systems

It is helpful to articulate the goals to be achieved by the Strategy, and specifically with respect to access and coordination. There are many ways to approach this, for example, reflections of key principles (e.g., population health, evidence-based) and/or specific approaches (e.g., recovery orientation, trauma-informed, increased equity and cultural safety) and/or specific features of the system to be improved such as “gaps in core services”, “more coordinated access”, “increased capacity for system navigation”, “improved transitions” and “increased collaborative care”. A program logic model may eventually be helpful in the implementation of the Strategy, or a subsequent performance measurement framework. Such a logic model would articulate the specific short-term, intermediate and long-term outcomes to be achieved and the mechanisms to get there. In the initial stage of the review process, the Consulting Team used a blended approach that identified key system features and key principles but with an eye to eventually articulating the broad vision of the Strategy, and related goals and principles. These system features and principles also serviced as a template with which to compare the current system with an ideal state. Three sets of principles or core system features were articulated at the outset.

The first is a set of core characteristics that have been articulated specifically for a high performing SUA/MH system⁷⁶. This has been built upon a systematic review of international and national literature and the list includes elements of structure, process and outcomes. In brief, an ideal SUA/MH system must achieve a “good score” on indicators organized across the following 10 domains:

1. **Acceptability** – services meet stakeholder expectations
2. **Accessibility** – services are available at the right place and time
3. **Appropriateness** – services are relevant to individual client needs and based on accepted standards
4. **Anti-stigma** – policies, services and activities and attitudes do not label or stereotype a person by their illness or personal challenges
5. **Competence** – provider knowledge and skills are appropriate to the service being delivered
6. **Continuity** – services are coordinated across programs, practitioners, organizations and levels of care over time
7. **Equity** – services do not vary in quality by client characteristics
8. **Effectiveness** – services achieve desired results

⁷⁶ Urbanoski, K. (2017). *Strengthening performance measurement for mental health and addiction in Ontario*. Toronto, ON: Centre for Addiction and Mental Health.

9. **Efficiency** – services achieve desired results with most cost-effective use of resources
10. **Safety** – potential risks (to clients, providers and environment) are avoided or minimized

These performance domains articulate, at a high level, the objectives for quality improvement and subsequent performance measurement. Importantly these domains also align well with the Triple Aim Framework for quality health systems⁷⁷. The term “Triple Aim” refers to the simultaneous pursuit of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care.

A second set of core system features or principles are articulated within VUCA, which is an acronym used to describe system or organizational capacity to respond to the **V**olatility, **U**ncertainty, **C**omplexity and **A**mbiguity of general conditions and situations. From its roots in military parlance, it is now used in strategic leadership in a wide range of organizations, including everything from for-profit corporations to education⁷⁸. The concepts embedded in VUCA are particularly *apropos* to SUA/MH planning, and the Manitoba situation, given many aspects of the aforementioned description of context and needs (e.g., the emergent crystal methamphetamine crisis). The four terms articulate system-level characteristics that require thoughtful and measured responses in strategic planning and organizational development, including governance structures and leadership capacities. Put simply, VUCA is an acronym for a practical code that signifies awareness and readiness.

V = Volatility. The nature and dynamics of change, and the nature and speed of change forces and change catalysts.

U = Uncertainty. The lack of predictability, the prospects for surprise, and the sense of awareness and understanding of issues and events.

C = Complexity. The multiplex of forces, the confounding of issues, no cause-and-effect chain and confusion that surrounds organization.

A = Ambiguity. The haziness of reality, the potential for misreads, and the mixed meanings of conditions; cause-and-effect confusion.

An ideal SUA/MH system is also characterized by **seven key principles** for system enhancement, principles that also assist in the review of evidence and serve as a template for system-level gap

⁷⁷ Following, in part, a report describing A Primary Care Performance Measurement Framework for Ontario (<http://www.hqontario.ca/portals/0/Documents/pr/pc-performance-measurement-report-en.pdf>)

⁷⁸ Bennett, N. & Lemoine, G.J. (2014). What VUCA really means to you. *Harvard Business Review*, 92(1-2).

analysis⁷⁹. The principles all contribute to a well-balanced, well-organized system that, in turn, helps to maximize access and coordination.

These seven principles are noted below and a brief explanation is provided in Appendix C. A summary in Table 1 below also illustrates the link to issues of access to, and coordination of, services.

Principle 1 calls for a broad recovery-oriented systems approach in order to address the range of SUA/MH challenges in the community as a whole, including, but not limited to, severe and enduring mental illness, in order to achieve a population-level impact.

Principle 2 articulates the importance of collaboration across multiple stakeholders as a necessary condition for enhancing accessibility and effectiveness of services.

Principle 3 concerns the system supports needed to facilitate and ensure the effective delivery of recovery-oriented services; supports such as policy, funding and planning models, performance measurement and evaluation systems, and support for knowledge transfer and implementation of evidence-informed practices.

Principle 4 articulates the importance of recognizing the unique strengths and needs of Indigenous people with respect to SUA/MH with a focus on enhanced physical, mental, emotional and spiritual health, and the benefit of services that blend principles and practices of “western medicine” with those based on traditional healing.

Principle 5 calls for consideration of evidence and issues related to developmental age, gender, equity and diversity in designing effective treatment and recovery support systems.

Principle 6 advocates for a full continuum of treatment and support services that begins with proactive, systematic screening to improve detection and access to required services, followed by systematic assessment and development of an individualized recovery plan that is matched to a full continuum of services and settings.

Principle 7 calls for the use of evidence-informed psychosocial and clinical interventions within these service delivery settings as the basis for effective treatment and recovery.

⁷⁹ Rush, B.R. (2017) *Research synthesis and evidence-based review in support of transformation of the mental health and addictions system*. Report to Manitoba Health, Seniors and Active Living. See also Rush, B. & Urbanoski, K. Seven core principles of substance use treatment system design to aid in identifying strengths, gaps and required enhancements. Under review for the *Journal of Studies on Alcohol and Other Drugs*.

Table 1. Relationship of the Seven Core Principles to Considerations of Service Access and Coordination

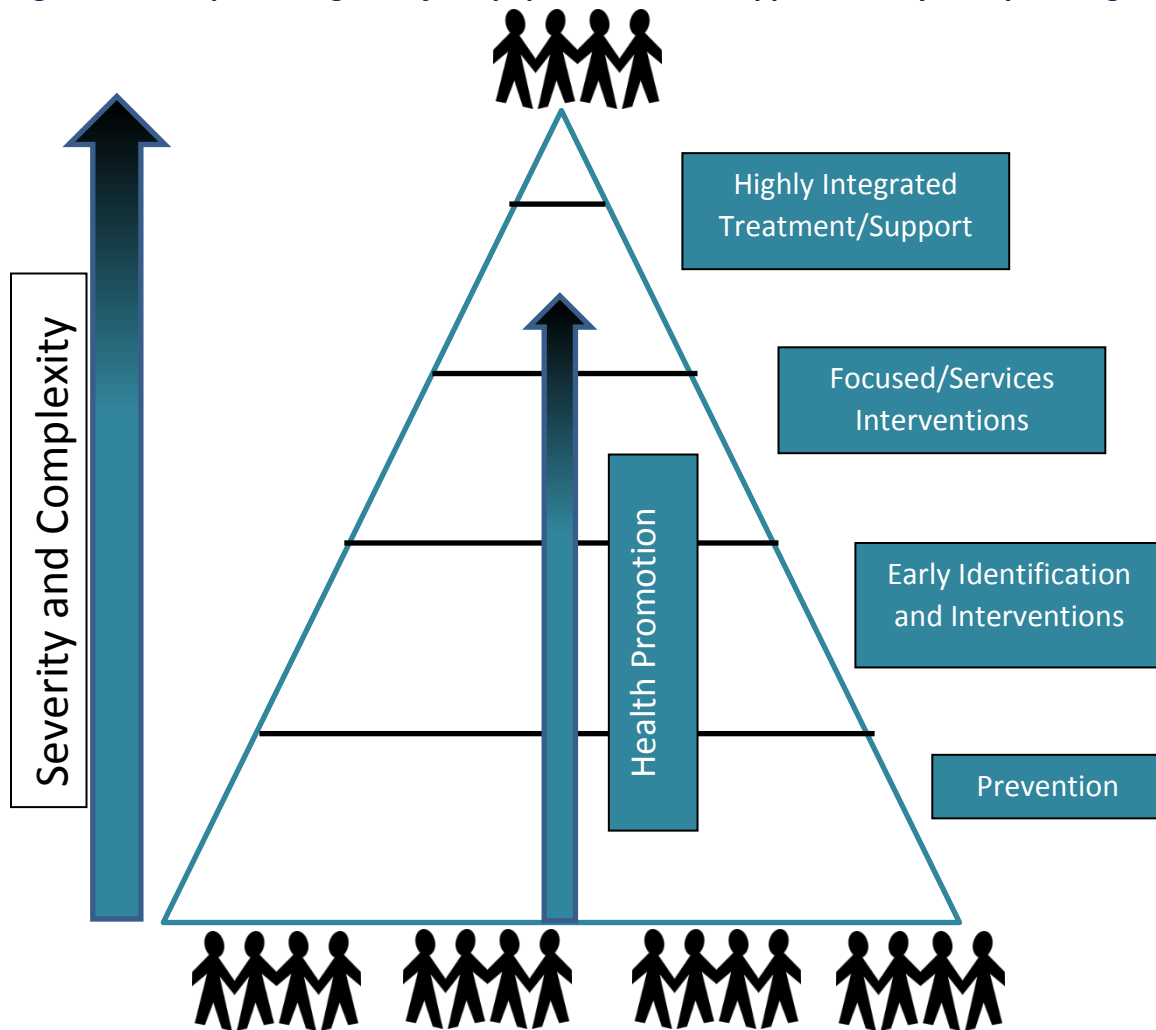
Core principle for system design	Some key relationships to access and coordination
Systems approach focused on population health	Encourages multi-sectoral response by enlisting support at multiple levels for access and facilitating coordination; increases focus on both prevention and early intervention and treatment of “moderate” levels of problems thus reducing incidence and alleviating demand; highlights capacity for measuring return on investment.
Collaboration	Increases system capacity for access as well as service provision; improves navigation either through centralizing one-stop shops or well-articulated pathways; expands overall reach of the system response.
System supports	Using needs-based planning, provides coverage targets by level of need; informs client flow patterns and facilitates safe transitions across providers; performance metrics identify hot spots and blockages in the system; identifies workforce competencies and diversity in relation to client characteristics and needs; improves welcoming and reduces no-shows and drop-out which impact wait times; improvements in workforce health reduces job vacancies that impact referral and coordination of care.
Indigenous peoples	Engages Indigenous communities, including health professionals, in system planning, which helps break down jurisdictional barriers that impact both access and coordination; increases in cultural competency of staff and cultural safety of clients that in turn encourages early help-seeking and reduces demand for the most intensive services.
Equity considerations	Ensures a focus on the question: <i>Access for whom?</i> - encourages a review of programs and policies that present population-specific barriers to access as well as continuity of treatment and support services; focuses attention on high need cases that are currently costly but with poor outcomes that can be improved with more coordination since they are accessing multiple systems concurrently.

Core principle for system design	Some key relationships to access and coordination
Continuum of care	Encourages a stepped approach and identifies gaps in treatment and support pathways that challenge coordination; focuses attention on screening and assessment and matching people to the right level of treatment and support and reducing wait times.
Evidence-based interventions	Ensures a focus on the questions: <i>Access to what? Coordination of what?</i> – encourages attention to the appropriateness and evidence underlying interventions, thereby improving outcomes, including recidivism and system flow. Facilitates a positive client and family experience thereby encouraging earlier access and recovery.

5.1 A tiered framework to help guide system enhancement

Principle 1 noted above advocates for a population-health approach to system planning; an approach which aims to address the needs of the whole community across a full spectrum of severity and complexity. This approach is illustrated conceptually in Figure 1 as a “population health pyramid”. In this conceptual model the population is considered in sub-groups based on severity and complexity, often called “tiers”, and a corresponding set of treatment, support and other services aligned with each tier. This includes prevention programs and services of particular relevance to those at the bottom of the pyramid. “Health promotion” is viewed as an appropriate activity across all levels of severity and complexity, for example health education regarding use of tobacco, and workplace and public policies focused on wellness. This model provides a conceptual framework for organizing the response to the wide range of community strengths and needs (see below). It will also be referred to again in a subsequent section on estimating the distribution of need in the Manitoba population and corresponding coverage of this need based on current service utilization (see [Section 6.3.3](#)).

Figure 1. Conceptual diagram of the population health approach to system planning



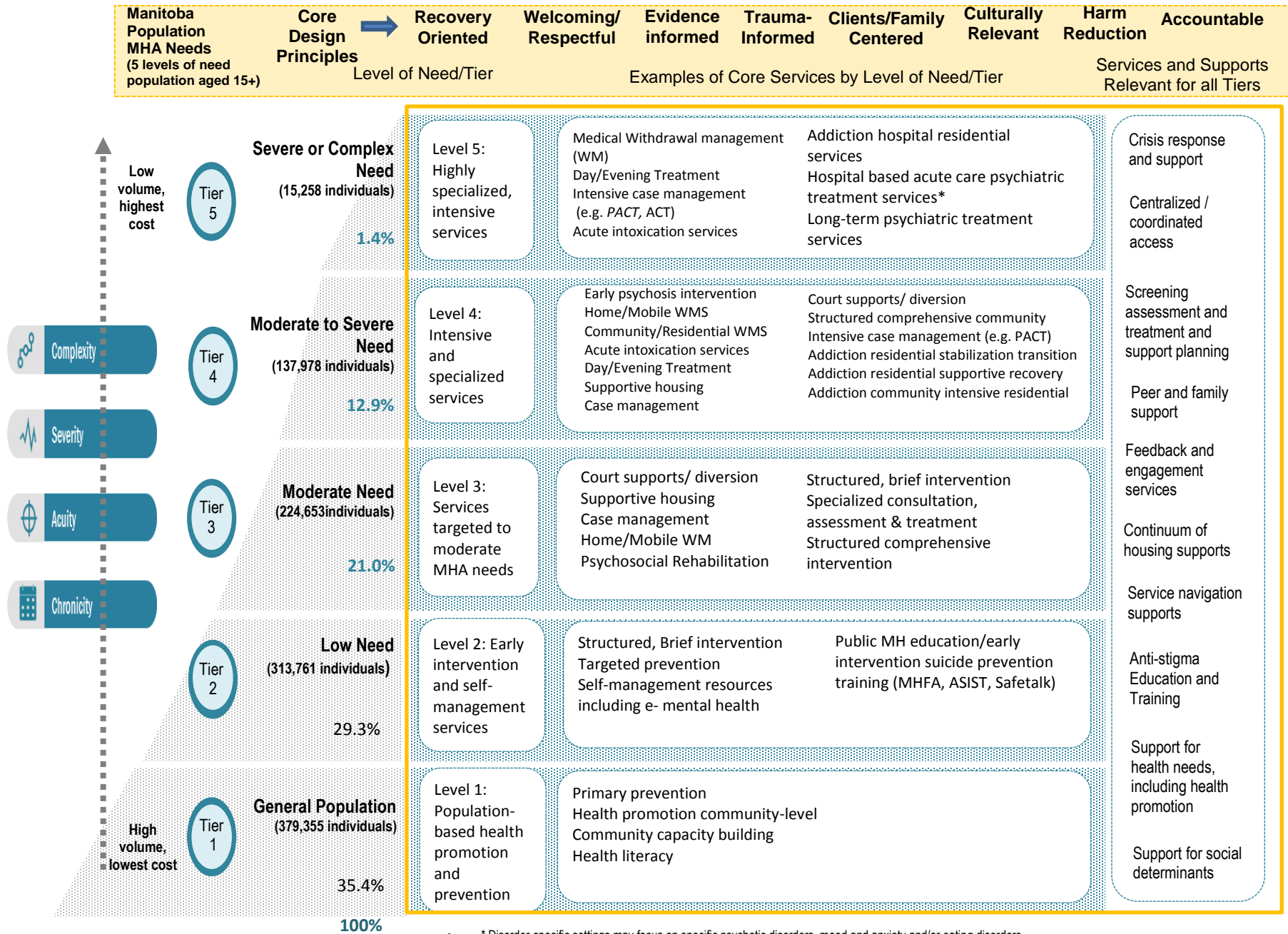
In Figure 2, a more complete conceptual framework is presented and with more detail *apropos* to the specifics of the Manitoba context. The left side of the diagram links back to the population health pyramid as described above and shows the estimated number of Manitoban's aged 15 and over in each need category. Importantly, this conceptual framework has been developed with the population aged 15 and over in mind, in part due to the availability of these population-based need estimates for this age group. In addition, an adapted conceptual framework could be developed for children and youth but developed in close collaboration with the Department of Families and other important stakeholders given the multi-sectoral nature of service delivery for this young population.

Some key features of the framework include:

- A set of core design principles to ensure are embedded in all processes and structures within the overall system⁸⁰.
- The tiered levels of severity and complexity and the corresponding estimates of the size of the Manitoba population aged 15 and over within each grouping.
- Examples of services categories within each tier, which are meant to be illustrative rather a complete set. It's important to note that some types of services can provide treatment and support services to more than one population sub-group. Also, as noted earlier, this list would need to be adapted considerably for children and youth services.
- On the far right side of the diagram, a list of services that are relevant to people at ALL levels of severity and complexity, for example, crisis response and support, coordinated access and navigation supports. Note the inclusion of supports for health needs as well as those relevant to social determinants such as housing (identified separately given its high need) and transportation and income, for example. The inclusion of these support illustrate, the intention behind a comprehensive framework such as this to prompt a "whole system and multi-sectoral response".

⁸⁰ These principles resonated strongly with stakeholders throughout the consultation and validation process and have been refined to be consistent to those principles subsequently identified as guiding the overall Strategy.

Figure 2. Mental Health and Substance Use/ Addiction Treatment System Framework for Manitoba



* Disorder-specific settings may focus on specific psychotic disorders, mood and anxiety and/or eating disorders.

6.0 CURRENT STATE

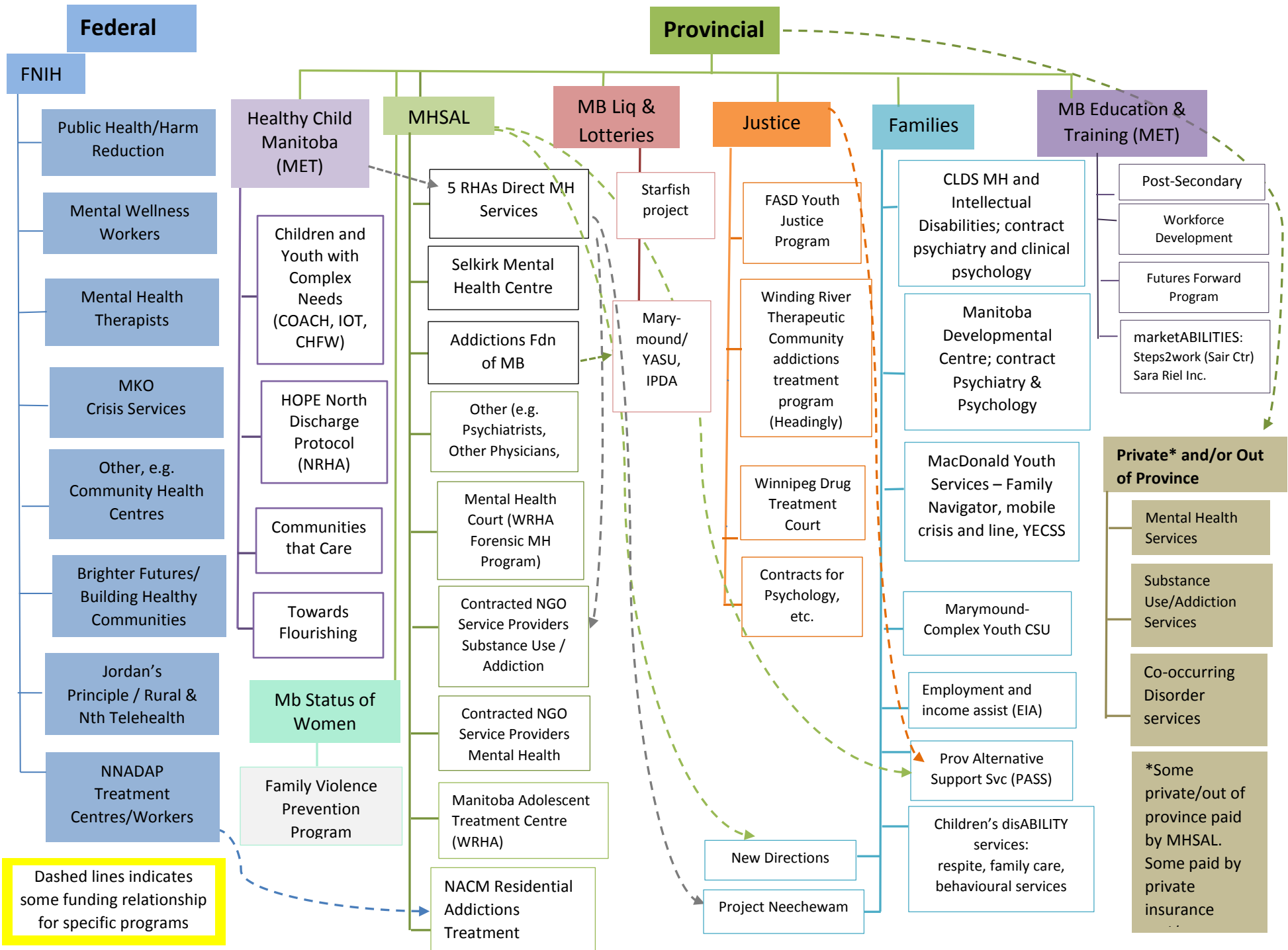
6.1 System Description

SUA/MH treatment and support services in Manitoba are delivered through a diverse array of organizations and programs, each tailored to specific strengths and needs of people seeking assistance. Figure 3 illustrates the scope, as well as the complexity, of the administrative and accountability relationships among the various funders and service providers. It's important to recognize the multi-sectoral response, which, on one level, is quite consistent with the “whole system/multi-sectoral” response noted above regarding the system-level conceptual framework. The multiplicity of players, however, should not be taken to mean a highly coordinated response. Some highlights include:

- The main service providers funded provincially under MHSAL (e.g., the RHAs, AFM, SMHC) but also the many services supported by Manitoba Education and Training, including HCMO, Manitoba Justice, Manitoba Status of Women and the Department of Families, as well as the funding through Manitoba Liquor and Lotteries Corporation for some specific addictions projects and services.
- The significant Federal contributions through First Nations and Inuit Health (FNIH).
- The significant privately run services as well as MHSAL-funding for out-of-province mental health and addictions treatment.
- The many inter-connections, which illustrate collaborative funding or accountability arrangements, in some instances with the same organization holding a contract with multiple players in the system (e.g., a contract with MHSAL as well as an RHA, and perhaps also with Justice, Families, or Education and Training).

This charting illustrates examples of the many funding and accountability arrangements and is not meant to be exhaustive, but rather is intended to illustrate the complexity of the various funding and accountability relationships, alluded to many times in the review of past planning processes and documents. Although all SUA/MH investments across these sectors could not be obtained in time to include in this chart, it emphasizes the current nature of the “whole of government” and “whole of society” response. While it may not necessarily be maximally coordinated, as implied by the earlier document review, multiple players are certainly engaged the delivery of SUA/MH services and supports, and in complex ways.

Figure 3. Overview of SUA/MH Administration and System Accountability Structures.



Below we offer a brief summary of the current delivery of SUA/MH services and supports in Manitoba. It is not intended to be an exhaustive detailed description, or a gap analysis in and of itself. Since some readers of this report will be more familiar with some parts of the system than others its important to get everyone on the same page more or less as an orientation to the subsequent sections on stakeholder feedback and operating characteristics such as wait times and occupancy levels.

Manitoba's substance use/addictions services: With respect to SUA services, the provincial picture is less complex than that of mental health more broadly, with the Addiction Foundation of Manitoba (AFM), a provincial crown agency, delivering about 90% of the services. Their offerings include a number of adult residential treatment services (men's, women's and co-ed) located in Winnipeg, Ste. Rose du Lac, Brandon, Thompson and Winnipeg, and which also offer various levels of community-based services. The residential services are typically 21-28 days in duration. Compass, the province's only residential youth treatment facility has 14 beds, is located in Southport, and is co-ed. AFM also has community-based offices at 26 locations throughout the province providing counselling, brief intervention and other non-residential supports, as well as on-site school-based services in over 47 schools and 20 divisions. AFM also offers Opioid Replacement Therapy (ORT) services in two of their locations – Winnipeg and Brandon.

The services of AFM are complemented by a range of service providers, the majority of which are contracted through MHSAL, but also include three Winnipeg Regional Health Authority (WRHA) contracted services and one Northern Health Region (NHR) contracted service. Those contracted through MHSAL cover the full treatment continuum although the majority offer only residential services of varying duration and orientation. For example, Behavioural Health Foundation (BHF), is a structured intensive residential program of 4-6 months in duration and which also has provision for family-based residential services, including children. Other programs such as Esther House and Addictions Recovery Inc. offer supportive recovery services, sometimes referred to as "aftercare" as they accept clients after they have completed more structured and intensive treatment such as at BHF, AFM or at other agencies such as Native Addictions Council of Manitoba (NACM), Salvation Army's Anchorage program, or Tamarack Recovery Centre. In addition to these contracted treatment services, the NHR operates Rosaire House, a long-standing residential treatment facility in The Pas and closely coordinated with the inpatient, acute care mental health services at The Pas General Hospital. The WRHA offers the Co-occurring Disorders Program (COD), a team of psychiatrists and clinicians with expertise in co-occurring SUA/MH. Resource Assistance for Youth (RaY), a street-level youth-focused organization funded primarily by the MHSAL and the Department of Families, provides resources to Winnipeg's street-entrenched and homeless youth up to age 29.

The WRHA also funds the Martha Street portion of Main Street Project (MSP), which offers withdrawal management services (WMS) for men. MSP's WMS for women is located at River Point Centre and is funded by MHSAL. The Martha Street facility also hosts an Intoxicated Persons Detention Act (IPDA) program which provides very short stays for managing acute intoxication with Paramedic assessment and support. The Health Sciences Centre (HSC) of the WRHA offers a medical withdrawal management unit focused primarily on alcohol and opioids. The Winnipeg Drug Treatment Court, which operates out of the Provincial Court of Manitoba, is available to offenders charged with drug-related and/or non-violent offences and who have been assessed as being dependent on drugs and whose criminal behaviour has been caused by, or motivated by, their addiction. The Youth Addictions Stabilization Unit (YASU), operated under the auspices of Marymount Inc. is a bedded unit located in Winnipeg for voluntary and involuntary addictions stabilization for youth under the age of 18. It also hosts two IPDA beds for youth. A SUA program known as Winding River operates within Headingley Correctional Centre. Lastly, a range of SUA services are offered through the federally-funded National Native Alcohol and Drug Abuse program (NNADAP) including several residential treatment centres - Sagkeeng, Native Addictions Council of Manitoba (NACM), Pritchard House, Peguis Al-Care, Nelson House Medicine Lodge and Norway House's Whiskey Jack (for youth). These residential services accept referrals from across the country. Some also offer community-based services (e.g., Peguis), while the majority of Indigenous community-based services are offered through local NNADAP workers.

In sum, the provincial network of specialized SUA services can be conceptualized as a continuum of treatment and recovery supports ranging from:

- Crisis stabilization and management of acute intoxication
- Withdrawal management in support of subsequent treatment engagement
- Outpatient, community-based services including ORT
- Structured, intensive residential treatment
- Supportive recovery and aftercare.

It is important to note that these specialized SUA services are also complemented by a range of more informal, peer-based supports, the best known of which are Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). In addition, Manitoba hosts the Manitoba Harm Reduction Network, a peer-based organization that engages in harm-reduction and peer-oriented projects aimed at reducing the negative consequences that may ensue from the use of legal and illegal psychoactive drugs. Needle exchange is led by RHAs (via their Public Health Programs). The Naloxone Distribution Program is led by MHSAL via the Active Living, Population and Public Health Branch)

Finally, it is important to note the critically important role of the many organizations that may be formally designated as “health” or “mental health” service agencies, but which offer services to people with SUA challenges, often in the context of their wider mandates. This includes, but is by no means limited to, Selkirk Mental Health Centre (SMHC), the Manitoba Adolescent Treatment Centre (MATC), community mental health services and housing supports offered through the RHAs, including Housing First services, or the regional offices of the Canadian Mental Health Association (CMHA), other community-based services such as Klinik, and the Laurel Centre. SMHC offers specific treatment and support for SUA and MATC operates the Youth Addictions Centralized Intake Service, a provincial service that offers information and support to parents regarding the Youth Drug Stabilization (Support for Parents) Act. It also serves to provide information to youth, their families, and allied professionals regarding SUA services for youth in Manitoba.

Manitoba’s grant-funded agencies such as Mood Disorders Association of Manitoba (MDAM), Anxiety Disorders Association of Manitoba (ADAM), Manitoba Schizophrenia Society (MSS) and Obsessive Compulsive Disorder Centre (OCDC) play an important role in the provision of peer-support services, information and navigation supports, as well as other services, including specific support groups for SUA (in the case of MDAM). Many Indigenous services play an important role in supporting people with SUA challenges (e.g., elders and other culture-based services, MKO crisis services, and local health centres). It’s also important to note the critically important role of Manitoba’s broader health services, including family physicians and other specialists (psychiatry in particular), as well as Emergency Departments (EDs) and mobile and other crisis services, hospitals, and community health centres/clinics. Services offered through other sectors such as Justice, Families and Education are also important to consider. Although these and many other formal and informal community resources may not specialize in substance use/addiction challenges, they do offer important services and, therefore, are considered part of the overall treatment and recovery support system.

Another important element of the provincial SUA treatment and recovery support system is the telephone helpline service offered by AFM. Historically, there have been two independently operated helplines—one for substance use and the other for problem gambling. These have recently merged into one service. Approximately 45% of the callers are looking for help for themselves and 40% for help for others.

In addition to these publicly funded resources available in Manitoba, there are a small number of privately run addictions treatment facilities such as Aurora Recovery Centre, Tamarack Recovery Centre, Whispering Pines, and Kelburn Estates. Manitobans also have access to treatment out of the province, pending referral by a specialist for application and approval by MHSAL.

Manitoba's Mental Health Services – With respect to mental health services, the RHAs play a much larger role than in the delivery of SUA services. There is, however, considerable variability in the nature and scope of the services under the auspices of the RHAs, for adults, as well as children and youth. The following gives a flavour of this variability and is not meant to be an exhaustive, highly detailed description of the RHA-based mental health services in each region. A detailed spreadsheet describing all of the province's SUA/MH services is provided to MHSAL as a separate project deliverable.

WRHA-based services

Psychiatric inpatient services - All the RHAs, with the exception of Interlake-Eastern Regional Health Authority (IERHA) and Southern Health- Santé Sud (SH-SS) have designated acute care psychiatric units in one or more hospitals. In the WRHA, for example, acute care services are offered in five different hospitals. Examples in the other regions include Brandon General Hospital (Prairie Mountain Health; PMH); and Thompson General Hospital (NHR). The MATC, which is part of WRHA, has some designated youth beds for intensive longer-term treatment for children and youth with psychosis-related or neurodevelopmental issues. The WRHA, through the HSC, supports the only acute paediatric inpatient psychiatry unit in the province. The IERHA has designated beds for adult acute care in the SMHC and in the SH-SS region, adult acute care beds are available in the Eden Mental Health Centre.

Psychiatry Services - The Department of Psychiatry of the University of Manitoba, linked to the WRHA, has several clinical programs covering a wide spectrum of adult, child and adolescent psychiatric disorders. These programs are offered through three main teaching institutions in Winnipeg: the Health Sciences Centre, St. Boniface Hospital, and Manitoba Adolescent Treatment Centre. The programs offered include: the Addictions Program, Ambulatory Care Program, Child and Adolescent Program, Community Psychiatry Program, Consult Liaison Program (HSC and SBGH), Eating Disorders Program, Emergency Consultation Service at the HSC, Forensic Psychiatry Program, Geriatric Psychiatry Program, General Psychiatry Program, Inpatient Psychiatry Program (SBGH), Mood Disorders Program, Schizophrenia Treatment and Education Program (STEP) and the Short Term Assessment & Treatment (STAT) Program

Clinical Health Psychology Services – The WRHA Clinical Health Psychology (CHP) Program of the University of Manitoba provides clinical services across the life span in the domains of health and mental health and across the spectrum of tertiary care (hospital) to primary care (i.e., community/primary care clinic) settings. The majority of services are provided in outpatient settings. Inpatient consultation services are primarily to the psychiatry units of various hospitals. Medical ward consults are often related to acute illness or injury adjustment, behavioural pain management or general behavioural concerns. The Program is organized into five areas of clinical service: Child and Adolescent Services, Adult Assessment Services, Adult

Treatment Services, Adult Health Psychology/Behavioural Medicine Services and Geriatric Services. Individuals presenting with primary SUA challenges are typically redirected to community and residential services as needed, for example, those offered through AFM.

Emergency and crisis services – Each of the RHAs support a number of hospitals with EDs and these are often accessed by people with SUA/MH challenges. In each RHA, there is one or more crisis services connected to a hospital, and these may operate on a phone-in, mobile, and/or walk in basis. In the WRHA, the Crisis Response Centre (CRC), developed with the intention to relieve pressure on Winnipeg EDs operates on a walk-in basis and also provides mobile crisis and Urgent Follow-up Intensive Treatment Team (UFITT) services. An affiliated adult Crisis Stabilization Unit (CSU) is also supported. In the SH-SS, the eastern half of the region is serviced by a mobile team and crisis phone service, while the western part of the region has after hours and weekend crisis and on-call services. An adult CSU is also supported. The IERHA offers two mobile crisis teams, one for adults and one for youth, as well as a 24-hour crisis line. This line is staffed by the Mobile Crisis Unit intake workers during the hours of 0800 to midnight and from midnight to 0800 the line is transferred to the Crisis Stabilization Unit (CSU) staff. The CSU is for individuals 15 years of age and over, and provides access to psychiatric consultation in person or via telephone for only those 18 years of age or older. The IERHA also supports a psychiatric emergency nurse in a mental health liaison role at Selkirk Hospital, providing both ED and inpatient assessment, consultation and treatment recommendations. The PMH provides a diverse range of crisis services including the Westman Crisis Services (mobile and a crisis unit), a Child and Adolescent Crisis unit, and a crisis response service in the northern part of the region. In the NHR, a youth mobile crisis team is affiliated with Thompson's Hope North Recovery Services for Youth, which also offers a 4-bed crisis unit and two beds for youth addictions stabilization.

Community mental health services: Every RHA offers a diverse array of community mental health services for both children and youth, as well as for adults, including, but not limited to, regular or intensive case management (ICT), Early Psychosis Prevention and Intervention Services (limited to the WRHA), services for medication management, psychosocial rehabilitation, proctor services, and specialized individual or group therapy such as Cognitive Behavioural Therapy (CBT) or Dialectical Behavioural Therapy (DBT). The Women's Health Clinic offers the Provincial Eating Disorder Prevention and Recovery Program and is funded by the WRHA. The WRHA operates the province's only Program for Assertive Community Treatment (PACT) teams for adults with severe and enduring mental illness. With respect to community mental health, in most instances there are separate child and youth teams, and often a dedicated team for older adults. Typically, there are also separate intake processes for these sub-populations. Most of the RHAs have developed formal shared care arrangements with primary care and/or other community health services (e.g., SH-SS, WRHA, IERHA, PMH). Also,

through RHA community mental health services, a limited range of housing with supports options are also operated directly by the RHAs or through contracted service providers.

Forensic services: Acute and rehabilitative inpatient forensic services are provided through the WRHA via the PX3 Unit at the HSC and through SMHC. At SMHC, patients are determined to require longer-term and intensive rehabilitation and treatment, and, ideally, will eventually transition to PX3 and then to community. The community forensic mental health system involves the Provincial Forensic Mental Health Program, operated by the WRHA, and the Winnipeg-based Mental Health Court, a partnership between the Department of Justice and the WRHA.

Telehealth: MATC and other RHA-based services provide consultation and support to clients and their health professionals in rural and remote parts of the province. Notably, the MATC has recently been contracted by the federal government to provide child and youth mental health services via telehealth to all First Nations communities throughout the province.

Non-RHA-based services

SMHC is the largest mental health facility and is operated directly by MHSAL. It offers six specialized programs including Acute Care, DBT, Acquired Brain Injury, Geriatric, Rehabilitation and Forensics. SMHC is a provincial resource, although as noted above, it has designated acute care beds for IERHA. It also routinely serves patients flown in from Nunavut (about 12% in 2016/17).

As with the SUA treatment and recovery support system, a diverse range of contracted service providers also play an important role in the mental health system. Some are contracted through MHSAL or another government department, while others are contracted through the RHAs. Some have contracts with both government and the RHAs. The largest of the contracted service providers are the regional offices of the CMHA, providing a mix of community-based services such as counselling and groups for people with co-occurring disorders, as well as supported housing and other housing alternatives.

The four grant-funded mental health “self-help” organizations, MDAM, ADAM, OCDC, and MSS, also provide an important contribution through an array of services. This can run the gamut from peer support services offered through phone, email, face-to-face support or group workshops, to responding to phone calls and emails for information and system navigation support to individuals and families. MDAM offers services, for example, in hospital, corrections and community settings. These self-help organizations also provide public education and advocacy activities.

Other contracted mental health service providers include organizations such as the Canadian Mental Health Association regional offices, The Laurel Centre, and Klinik, each providing a unique and important set of services. The Laurel Centre, for example, specializes in long-term therapy for female victims of childhood sexual trauma; Klinik offers counselling and also

operates a wide range of crisis and helplines; and the Salvation Army runs Haven, a long-term residential mental health facility for people with very severe and enduring mental illness, and is funded by WRHA.

As with the province's SUA services, and illustrated in [Figure 3](#), it is also important to note that sectors other than "Health" are also providing significant mental health services for adults, as well as for children and youth— in particular, services through the Department of Families, Education and Training, and Justice. For adults, these services include treatment and support for adults with a dual diagnosis, that is, both mental illness and a developmental disability. The Department of Families also operates the Manitoba Development Centre which runs a secure unit for those with dual diagnosis and a low threshold intellectual disability, and who are deemed to be at risk of harming themselves or others. The Department of Families also funds a wide range of child and youth mental health services (e.g., MacDonald Youth Services, Marymound). Marymound operates the Complex Needs Unit, a residential treatment service for girls under age 18 with highly complex needs.

Other examples of multi-sectoral involvement are the Aurora Therapy Program for Immigrant and Refugee Families funded by Manitoba Education and Training, and the Gang Prevention initiative funded by the Department of Justice. The NorWest Co-op Community Health Centre hosts a youth hub that brings a wide array of youth oriented mental health and substance use/addiction services together in a collaborative model; one of their youth-focused programs, Intervention and Outreach Team (IOT) is funded by HCMO.

The Healthy Child Manitoba Office (HCMO) was intentionally constructed as a multi-sectoral collaborative partnership across the Government of Manitoba and was charged to create and implement a long-term, cross-departmental strategy for supporting Manitoba's children, youth and families. A wide array of prevention and service-oriented projects are implemented and evaluated. This includes, but is by no means limited, to the following: a longitudinal study and outcome evaluation of children and youth with the most complex, multi-system needs; PAX: Good Behaviour Game; High Fidelity Wraparound; Towards Flourishing; the Early Development Instrument; Intervention and Outreach Team (IOT), and the Protocol for Assessment and Discharge of Suicidal Children and Youth in Thompson and area. They also support a wide range of special studies in collaboration with partners such as the MCHP.

Also, as with SUA services in Manitoba, many mental health and wellness services and supports are offered through the First Nations and Inuit Health Branch (FNIHB) and community-based Indigenous services. This includes the Manitoba Keewatinowi Okimakanak Inc. (MKO) Mobile Crisis Response team that provides holistic, culturally sensitive and safe crisis response and trauma interventions to Manitoba's First Nation communities. Services include, but are not limited to, critical incident stress debriefing, sharing circles, one-on-one counselling, mental health therapy, grief and loss support, post-suicide response, and individual client assessments, such as suicide assessment and safety plans. Other important services are provided by community mental health wellness workers, staff associated with Brighter Futures/Building

Healthy Communities, services falling under Jordan's Principle, elders and other traditional supports, and community health services. Coverage is also provided for mental health and crisis counselling under Health Canada's Non-Insured Health Benefits (*NIHB*) Program for First Nations and Inuit.

Primary care physicians, psychiatrists and a range of other health and social service professionals, such as psychiatric nurses, psychologists, pharmacists and social workers, also play critically important roles in the provincial mental health system, as they do with SUA services. The majority of physicians, including psychiatrists, work independently or in a group practice and bill MHSAL on a fee-for service basis. Others are supported on a dual funding model, paid partly on a salaried basis and partly through fee-for-service billing. Some psychiatrists and psychologists are contracted through other government departments.

Lastly, as was noted for the important role of mental health services in supporting people with SUA challenges, it is important to acknowledge the work of SUA service providers in supporting people with mental health problems and illnesses since a significant percentage of their clients experience co-occurring disorders.

6.1.1 Manitoba's Investment in SUA/MH Services and Supports

Table 2 provides a breakdown of estimated funding directed to SUA/MH services and recovery supports in Manitoba, totaling just over \$506.3 million for 2016/17 with the bulk of that (65.2%) invested by MHSAL (\$330,761,751). Of the MHSAL investments, the RHAs accounted for 53.0%, followed by physician billing (19.0%), and SMHC (15.3%). The total cost of out-of-province treatment, amounted to \$1,009,880 in 2016/17, or about 0.3% of the total MHSAL expenditures for SUA/MH.

For SUA specifically, we would combine across the first three categories in the table, and also include the Manitoba Liquor & Lotteries funding support to the AFM (e.g., for YASU). This yields a total of \$38,684,171, the large bulk of this being accounted for by the AFM.

The lower section of Table 2 also illustrates the costs beyond MHSAL specifically and it is here that some estimates have had to be made by the many organizations and Departments supporting the compilation of these data. The major challenge is that while many of the additional investments from outside the MSHAL are very directly in support of SUA/MH services (e.g., Manitoba Liquor and Lotteries; some costs within Families such as EIA support for people with mental health-designated disabilities), many other investments support people with SUA/MH challenges but these challenges are among other that the individuals or families are experiences (e.g., family violence programs of Manitoba Status of Women). In other instances, relevant program costs could not be estimated, for example, when there are challenges identifying individuals with SUA/MH challenges receiving various services but they may not be so identified in reporting systems of significant programs, for example, non-EIA Rent Assistance or Manitoba Child Benefit.

So, in the end, we present this global figure of approximately a half billion dollars as a reasonable estimate of the total Manitoba investment in SUA/MH-related costs and acknowledge it is likely somewhat of an underestimate. Although perhaps under-estimated, the additional investment outside of MHSAL specifically is sufficient to tangibly demonstrate the direct involvement of multiple government departments in Manitoba in SUA/MH-related services and supports.

Using the funding of MHSAL as the most direct estimate of SUA/MH investment, the total of \$330,761,751 represents 5.1% of the total health budget for 2016/17, which was \$6.497 billion. Considered as the percentage of total expenditures (\$16.291 billion) the overall total estimate of \$506,345,382 represents 3.1 %. While this represents a significant investment of public funding, this doesn't necessarily mean the investment is an adequate allocation of health funding in order to meet the high level of community need identified in [Section 4.0](#) above. As noted earlier the national benchmark in Canada is 7.2% and this even falls short of the dedicated funding for mental health in most high-income countries. Nor does it mean the current investments are being used to maximize efficiency and achieve optimal outcomes.

Table 2. Estimated Public Investment in Manitoba's SUA/MH Services and Supports, 2016/2017

Funding Area	Amount	Percentage of MHSAL	Percentage of TOTAL
Addiction Foundation of Manitoba (AFM)¹	\$28,434,784	8.6	5.6
Contracted Addiction Agencies²	\$6,887,400	2.1	1.4
Provincial Special Needs Program (PSNP)	\$551,000	0.2	0.1
Regional Health Authorities (Mental Health)	\$174,935,600	53.0	34.5
Selkirk Mental Health Centre (SMHC)	\$50,385,000	15.3	10.0
Contracted Mental Health Agencies	\$2,963,700	0.9	0.6
Physician Billing Costs	\$62,783,400	19.0	12.4
Out of Province Treatment (Total)	(\$1,009,880)	(.33)	(0.19)
Addiction		0.1	0.04
Mental health	\$226,219	0.1	0.04
Co-occurring addiction and mental health	\$477,208	0.1	0.09
Eating disorder	\$91,488	0.03	0.02
MHSAL Department/Branch Costs	\$2,232,800	0.7	0.4
Sub-total (MHSAL)	\$330,761,751	100.0	65.2
Manitoba Liquor & Lotteries³	\$2,810,987	N/A	0.6
Healthy Child Manitoba Office	\$6,860,300	N/A	1.4
Department of Families⁴	\$152,786,700	N/A	28.8
Manitoba Justice⁵	\$12,340,273	N/A	2.4
Manitoba Education and Training⁶	\$1,363,498	N/A	0.3
Manitoba Status of Women⁷	\$7,159,800	N/A	1.4
TOTAL	\$506,345,382	N/A	100.0

¹ Includes \$8,495,771 from other government sources including Manitoba Liquor & Lotteries

² Includes agencies contracted through the RHAs

³ Funding support in addition to that for AFM (e.g., YASU)

⁴ Includes, for example, EIA benefit payments to EIA clients with an identified mental health disability (\$135 million); psychiatric nurses as well as contracted psychiatry services as part of the Community Living disAbility Services program and the Manitoba Development Centre (\$1,215,000) and various programs within Childrens disAbility Services (\$8,154,300).

⁵ From the Community Safety Division

⁶ From the Post-Secondary Education and Workforce Development Division

⁷ From the Family Violence Prevention Program

In addition to garnering an overall assessment of the public investment in SUA/MH services in the province, a supplementary request went to the RHAs concerning trends in their operating budgets over the past five years. Details requested covered trends in the overall budget, trends for acute inpatient versus outpatient/community-based services, strategies for mitigating budgetary challenges, and percentage budget allocations for training, guideline development or evaluation. It is challenging to provide an aggregate provincial picture given variations in how the information was provided to the consulting team. Overall, for the RHAs, the following trends emerged:

- Small percentage increases (less than 5%) were evident in the five-year period, but much smaller increases or no increase from 2016/17 to the current year, 2017/18 (between -.2% and about 2%).
- Any changes were due largely to increases in budgetary lines for salary rather than other operating costs. Salary changes tended to reflect increases in salary scales rather than new managers or staff.
- New funding outside salaries was dedicated to some new programs (e.g., CRC in the WRHA; Hope North in the NHR).
- Strategies to mitigate disparity between increased costs were essentially through shifts in the usage of existing positions, management of vacancies, and reductions in Manager positions (e.g., PMH lost three managers since 2013; WRHA lost 5 management positions or a 15% management reduction in 2017).
- Tracking training costs proved to be a challenging task and with considerable variation across the regions. In some instances, no specific budget line dedicated to training could be identified (e.g., in the NHR) and training was often undertaken on a cost-recovery basis and/or with internal resources. This was also often the case for participation in research and program evaluation. These functions were better defined and resourced in the WRHA given, for example, the relationship with the HSC and the MCHP, and opportunities available for external funding.

Information was also obtained on pay equity across different organizations and sectors, an issue that had been identified in the consultation with respect to recruitment and retention. Significant differences in salaries were evident between non-unionized contracted service agencies and unionized AFM, for example. Other examples were reported for comparators across the RHAs and community services, including Indigenous-based services.

Significant salary/income differentials were also reported for contracted psychiatrists through the justice system compared to those working under the auspices of the RHAs or SMHC.

6.1.2 Summary of system overview and implications

The following are some highlights of the system overview presented above.

Investment is significant: The province's investment in SUA/MH related services is estimated at just over \$506.3 million, of which \$330.7 million or about 65% represents health funding. The health investment represents 5.1% of the total health investment and is below the national benchmark. The investment begs the important questions as to whether it is sufficient to meet the needs of the population and also whether outcomes are being maximized with the current system of services, in terms of both structure and processes.

Investment is multi-sectoral: Although the largest share of the investment comes through the MHSAL, it is very multi-sectoral in nature and involving several departments of the provincial government as well as FNIH at the federal level and the private sector. The multi-sectoral make-up of the system provides a strong foundation for a coordinated "whole of government/whole-of-society" response". This includes already strong engagement of sub-sectors within MHSAL, including primary care.

Multiple lines of funding and accountability: There are multiple players involved in the overall system of SUA/MH and, multiple service providers funded directly or indirectly by the MHSAL (e.g., RHAs, AFM, SMHC, MATC; many contracted providers). This reinforces observations made in several previous planning processes of an overly siloed system. The current structure of the provincial system of SUA/MH services and supports highlights the separation of the mental health and SUA services in the province.

Specialized services are the foundation: That being said, each "system" (SUA and mental health operates a continuum of services generally similar to that offered in many other Canadian jurisdictions, albeit with significant regional variation. Although are significant gaps, and especially with respect to regional the current system provides a solid foundation on which a more accessible and coordinated system can be built.

Importance of community-based and other supports: The descriptive overview of the system also highlights the important role being played by community-based services and a range of self-help organizations. It is important to retain these strengths in the system while addressing broader issues related to structure, funding and accountability.

Federal/provincial relationships are critical: The significant involvement of FNIH-funded services highlights the importance of addressing jurisdictional issues so frequently noted in previous planning processes and documents reviewed, as well as the higher level of need among Indigenous people illustrated by the previous summary of need indicators across the province.

6.2 What We Heard from Stakeholders

6.2.1 Manitoba on-line mental health and substance use/addiction survey

The participation rate in the on-line survey conducted as part of this review, as well as the promptness with which people responded (the majority in the first two days of its on-line posting), is a strong indicator in and of itself about the level of interest and commitment to the Strategy and the opportunity to offer input. A total of 3803 people responded to a series of structured questions about the province's SUA/MH services - 2080 members of the general public and 1723 service providers. Survey respondents could respond to questions either for mental health services, substance use/addiction services, or both. They could also choose to respond for particular age groups – children (birth – 11), youth (12-17), young adults (18-25), adults (26-64), or older adults (65 or older).

An analysis is presented below of the quantitative survey results, beginning with characteristics of respondents from the general public, followed by those of service providers. This is followed by the thematic qualitative analysis of the responses to the open-ended questions that were also included in the survey.

The main limitation of the survey to keep in mind, while reviewing and interpreting the results, is that the survey was implemented with an on-line invitation that was advertised widely through various organizations and stakeholders and through a public announcement by the Government of Manitoba in a news release on Sept 18 2017⁸¹. Thus, it is not a representative sample of the Manitoba general public and may have encouraged a response from people who are biased in a particular direction. That being said, the intention was to encourage people with direct experience to offer their views, not the general public writ large. Also, there is no *a priori* reason to expect that the opportunity to respond would have differentially encouraged responses from those with more or less positive experiences.

Table 3 shows the survey was successful in attracting a diverse group of people from the general public. Importantly, 515 general public respondents did not complete the demographic items so this analysis is based on the remaining participants. The sample size for each demographic variable varies slightly due to a small amount of additional missing data for each item.

Highlights include:

- About 79% of respondents were female
- About half were between the ages of 46-65
- 52.8% reported living in the Winnipeg Regional Health Authority

⁸¹ <http://news.gov.mb.ca/news/index.html?item=42152>

- 83% were primary English speakers and about 95% reported routinely speaking English at home
- 14.2% reported having an Indigenous background
- A minority were immigrants to Canada and the year of entry was highly variable
- About a third (34.1%) reported an annual income before taxes between \$50,000 and \$100,000
- Over 40% indicated ever having trouble making ends meet at the end of the month

Keeping in mind we do not know the demographic characteristics of about 25% of the general public sample, it is not possible to make strong statements about how representative the sample is of the general public. We also do not know the characteristics of people with some personal or familial experience with Manitoba’s mental health and substance use/addiction services, the true target population. We do know that the survey attracted significantly more women than men, and relatively fewer adolescents, young adults and people over the age of 64. Data not shown here indicate that the response to the survey achieved good comparability to the regional distribution of Manitoba’s population. Income comparators are challenging but it is estimated that the survey did not draw a representative sample of low income or marginalized populations, including newcomers and refugees.

Table 3. Demographic Characteristics of General Public Survey Respondents

Respondent Characteristics	N	%⁸²
Gender		
Male	242	15.5
Female	1242	79.6
Transgender/Other	15	1.0
Prefer not to say	62	4.0
Total	1561	100.1%
Age		
0-17 years	4	0.3
18-24 years	64	4.1
25-44 years	610	39.1
45-64 years	732	46.9
65 years or older	99	6.3
Prefer not to say	52	3.3
Total	1561	100%
Regional Health Authority of Residence		
Winnipeg Health Authority	823	52.8
Interlake-Eastern	130	8.3
Southern Health	274	17.6
Prairie Mountain Health	205	13.1

⁸² Total may not equal 100 due to rounding

Northern	63	4.0
On-Reserve	18	1.2
Prefer not to say	47	3.0
Total	1560	100%
Able to speak English or French?		
English Only	1291	83.0
French Only	4	0.3
Both English and French	226	14.5
Neither English nor French	2	0.1
Prefer not to say	33	2.1
Total	1556	100%
Language spoken at home		
English	1467	94.2
French	41	2.6
Other	33	2.1
Prefer not to say	17	1.1
Total	1558	100%
Country of Birth		
Canada	1452	93.6
Outside Canada	52	3.4
Prefer not to say	48	3.1
Total	1552	100.1%
Indigenous background		
No, not an Indigenous person	1224	78.5
Yes, First Nations	82	5.3
Yes, Metis	137	8.8
Yes, Inuk (Inuit)	1	0.1
Prefer not to say	116	7.4
Total	1560	100.1%
*If born outside Canada, residency status		
Permanent Resident	38	71.7
Immigrant	6	11.3
Refugee	2	3.8
Prefer not to say	7	13.2
Total	53	100%
*If born outside Canada, year moved to Canada		
1950 – 1959	4	8.2
1960 – 1969	5	10.2
1970 – 1979	12	24.5
1980 – 1989	10	20.4
1990 – 1999	5	10.2
2000 to present	13	26.5

Total	49	100%
Annual household income before taxes		
\$25,000 or less	155	10.0
\$25,001 - \$50,000	274	17.7
\$50,001 - \$100,000	529	34.1
\$100,001 - \$200,000	303	19.5
\$200,001 or more	47	3.0
Prefer not to say	24.3	15.7
Total	1551	100%
Ever having trouble making ends meet at the end of the month		
Yes	653	42.1
No	667	43.0
Prefer not to say	231	14.9
Total	1551	100%

Table 4 follows and shows demographic characteristics of the participating service providers. Highlights include:

- A good cross-section of providers focused on both mental health and substance use/addiction (35.1%), primarily mental health (20.5%); or primarily substance use/addiction (6.7%), as well as more “generalists” who provide services to people with mental health and/or substance use/addiction challenges on their routine caseloads.
- Of those providing these more generalist services, over a third (37.8%) reported their primary mandate as health, 16.1% as child and family and 13.6% as education. 22.5% reported multiple mandates.
- The vast majority (93.2%) reported working with both men and women.
- 60.8% reported working closely with Indigenous people and a good distribution was obtained in terms of work across the various regions of the province.
- The majority (70.3%) were front-line service providers but managers (10.9%) and other levels were also represented to some degree.
- Reported disciplines varied widely; respondents with nursing backgrounds (34.8%), social work (23.9%), psychology (11.2%), and addiction medicine (8.6%) making up over two-thirds of the sample.
- Almost half (49.1%) reported 2 years of experience or less in their current field and 38.3% reported 3-10 years.
- Region/location of work was distributed across the province with the large majority endorsing multiple options.
- In terms of jurisdiction, respondents were almost evenly split into thirds – regional (35.5%), local (33.8%) and provincial (27.0%).

Table 4. Demographic Characteristics of Service Provider Respondents

Respondent Characteristics	n	%
Involvement with mental health or substance use/addiction challenges		
I/my organization provide services primarily to people with BOTH mental health and substance use/addiction challenges	605	35.1
I/my org. primarily provide OTHER types of services but have people w/ MH AND/OR SU challenges on my/our caseload	601	34.9
I/my organization provide services primarily to people with mental health challenges	353	20.5
I/my organization provide services primarily to people with substance use/addiction challenges	116	6.7
OTHER	48	2.8
Total	1723	100%
If providing OTHER types of services, the primary mandate of the service		
Health	244	37.8
Combination of services	145	22.5
Child and Family Services	104	16.1
Education	88	13.6
Justice/Corrections	37	5.7
Employment and Income Assistance	27	1.6
Total	645	100%
Age Group(s) Service Primarily Provided to		
Adults (18 and older)	872	50.6
Children and youth (17 and under)	243	14.1
All age groups (both children, youth and adults)	608	35.3
Total	1723	100%
Gender Group(s) Service Primarily Provided to		
Men/Boys	32	1.9
Women/Girls	84	4.9
Both gender	1607	93.3
Total	1723	100.1%
Work closely with Indigenous peoples		
No	676	39.2
Yes: ⁸³	1047	60.8
Total	1723	100%

⁸³ Work with Indigenous peoples included: Programming and services specifically utilized or targeted by First Nations; Work directly with First Nations communities on/off-reserve (e.g. Telehealth); Contracted to work specifically with First Nations

Primary role		
Front-Line Service Provider	1212	70.3
Manager	187	10.9
Clinical Lead/Coordinator	152	8.8
Executive Leader	78	4.5
Other ⁸⁴	48	2.8
Administrative support	46	2.7
Total	1723	100%
Discipline		
Nursing	427	24.8
Social Work	412	23.9
Psychology	193	11.2
Addiction Specialist	148	8.6
(Peer) Support worker / proctor	115	6.7
Primary Care/General Medicine/Specialty/Allied Health	97	5.6
Social Services/Counselling/Therapy	68	3.9
Psychiatry	58	3.4
Education	56	3.3
Program Administration/Management/Support	42	2.4
Other ⁸⁵	41	2.4
Occupational Therapy	37	2.1
Health Promotion/Education	17	1.0
Legal/Criminal Justice	12	0.7
Total	1723	100%
Number of years working in your current field		
2 years or less	846	49.1
3 to 10 Years	665	38.6
11 years or more	212	12.3
Total	1723	100%
Geographic area of work on a daily basis⁸⁶		
Winnipeg	854	NA
Prairie Mountain Health	328	NA
Interlake-Eastern	246	NA
Southern Health	230	NA
Northern	151	NA

⁸⁴ Primary Role - Other includes: Clinical Educators, Consultants, Peer Support/Mentors, Resource Development, Trust Administrator - facilitate initiative, working in collaboration with Addictions Foundation of Manitoba, Research and Education, Come across different cultures in my job, grandparent, Board Member, self-employed, Community Development Facilitator, Community Health Developers, Research, Mandating Authority

⁸⁵ Discipline – Other includes: Academics, Spiritual Health Providers and individual responses that did not fall into available categories

⁸⁶ Service Providers could work in multiple geographic areas

On-Reserve	77	NA
Prefer not to say	52	NA
Catchment area for services provided by organization		
Regional	611	35.5
Local	582	33.8
Provincial	465	27.0
National	65	3.8
Total	1723	100.1%

6.2.1.1 Quantitative survey results

With two exceptions⁸⁷, both service providers and the general public respondents offered their opinion on the same set of quantitative items about Manitoba’s mental health and/or substance use/addiction services. There are many ways to organize these data and, after reviewing the results, the consultant team decided the most informative was to compare the responses to the questions from service providers and the general public. These data are summarized in Table 5 by showing the level of disagreement (which predominated responses to most questions) across these two groups and for the mental health and substance use/addiction questions separately. For a more visual representation of the findings, the responses to a small number of questions are presented graphically below. In addition, Appendices D through G show graphs of all comparisons made. Appendix D shows results comparing service providers and the general public; filling in details for all the comparisons shown in Table 5 below. Appendices E through G then provide a similar set of graphs comparing the responses for mental health versus substance use/addiction (Appendix E), the responses based on reported years working in their field (Appendix F), and finally the responses based on the age of the target group the respondents had in mind when responding (Appendix G).

Turning attention first to Table 5, items are grouped around a small number of domains into which the items cluster – accessibility, appropriateness, engagement, continuum of services, coordination and overall perceptions. There are some resulting patterns in the data that are clearly evident while others take a bit more focus to tease out. Moving back and forth from the table to the corresponding graphs in Appendix D may be helpful in some instances, for example, to see the proportion of people responding “don’t know”, which can impact the percentages agreeing or disagreeing with an item⁸⁸.

⁸⁷ One question about days and times of days of services was inadvertently omitted from the general public version. Another item on processes for reviewing evidence was considered appropriate only for service providers.

⁸⁸ We deliberately chose to include “don’t know” responses in the denominator of these percentages, as it is also a response of interest in its own right, that is, not really “missing data”.

The most noteworthy pattern across the entire group of sub-domains and individual items were higher levels of disagreement (i.e., a more negative opinion on the system characteristic) among the general public compared to service providers. This pattern held for responses to mental health as well as the substance use/addiction services.

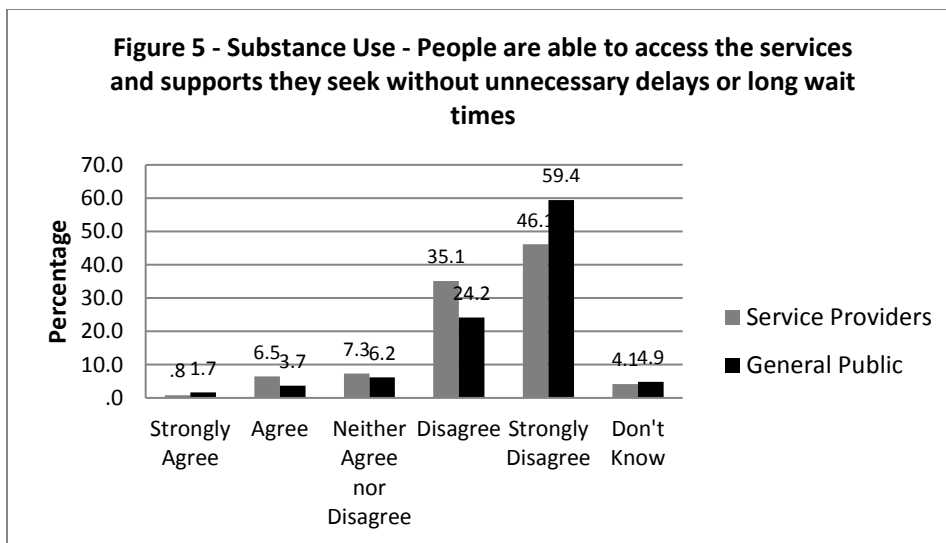
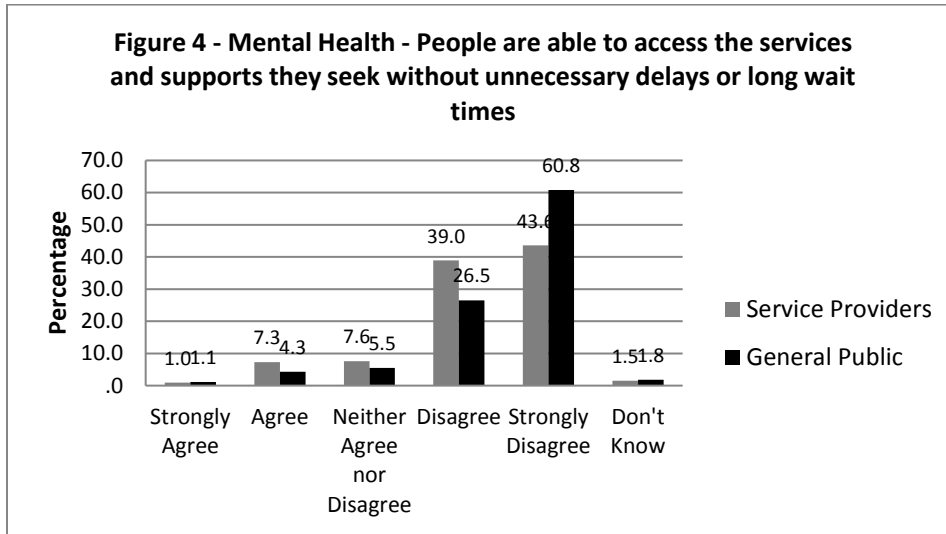
Table 5. Summary Table Comparing Service Providers and General Public on Perspectives Regarding Mental Health and Substance Use/Addiction Services

	Mental Health		Substance Use/Addiction	
	Service Providers	General Public	Service Providers	General Public
	COMBINED % Who Disagree or Strongly Disagree			
Accessibility				
Information about mental health OR substance use/addiction services and supports is readily available and accessible	39.8	64.2	35.0	49.8
Regardless of the kind of services or supports (such as mental health clinic, detox, treatment program, doctor's office) people start with, <i>they are able to access other services or supports without too much difficulty</i>	68.2	80.5	69.0	75.3
People are able to access the services and supports they seek <i>without unnecessary delays or long wait times</i>	82.6	87.3	81.2	83.6
People are able to access most services and supports <i>in or near their home community</i>	56.6	64.7	64.2	67.9
People are able to access services and supports <i>without being limited by factors such as language, gender, sexual orientation or age</i>	31.9	37.9	33.0	40.5
People are able to access services and supports on days and times of day that fit with their schedules	53.6	N/A ⁸⁹	56.8	N/A ⁸²
Appropriateness				
People are able to obtain services and supports that are appropriate for <i>the kinds of problems they are experiencing (such as mood or anxiety related challenges)</i>	40.3	64.5	47.0	62.7
People are able to obtain services and supports that are appropriate for the <i>severity (seriousness) of the problems they are experiencing</i>	53.9	72.1	58.0	72.5
People are able to obtain services and supports that are <i>sensitive and appropriate to their cultural needs</i>	38.6	38.7	36.9	41.0
Mental health OR substance use/addiction services and supports have strong processes for reviewing evidence and making the appropriate program enhancements	40.1	N/A ⁸²	35.4	N/A ⁸²

⁸⁹ Question was not asked to people with lived experience

Engagement				
Out of the available services and supports, people are able to choose from a range of approaches (such as different kinds of counseling or self-help) to help address their mental health OR substance use/addiction challenges	55.9	69.1	50.6	62.8
Service providers (such as counselors) are able to explain the reasons for the practices they follow or recommend	13.5	31.9	12.7	30.4
People receiving services and supports are able to set their own goals	16.9	31.3	18.4	27.0
Continuum of Services				
There is a wide range of mental health OR substance use/addiction services and supports to meet the diverse (different) needs of people <i>at risk for</i> mental health OR substance use/addiction challenges	68.6	77.3	66.8	73.2
There is a wide range of services and supports to meet the diverse (different) needs of people <i>experiencing</i> mental health OR substance use/addiction challenges	62.4	76.4	64.0	74.6
There is a wide range of services and supports to meet the diverse (different) needs of people (such as families, other loved ones) who are <i>affected by someone else's</i> mental health OR substance use/addiction challenges	68.9	76.3	61.3	69.5
Coordination				
Service providers (such as counselors, intake workers) are well informed about other services and supports offered in the region	26.3	40.8	28.1	37.3
The agencies or programs that provide different types of mental health OR substance use/addiction services work well together to help people access the services they need/ want at any given point in time	44.7	62.7	38.7	55.0
The agencies or programs that provide different types of mental health OR substance use/addiction services work well together to support clients as they transition from one agency or program's services to another's to help address their continued/changing needs	46.8	59.1	44.4	53.8
Overall				
Services and supports are able to adapt to the changing needs and preferences of people seeking help with mental health OR substance use/addiction challenges	48.0	63.4	47.7	56.5
Taken together, the available services and supports are able to meet the level of demand for them (there are enough services and supports)	83.7	84.9	80.9	78.5
The services and supports for people with mental health OR substance use/addiction challenges are of high quality	33.0	52.1	35.2	50.1

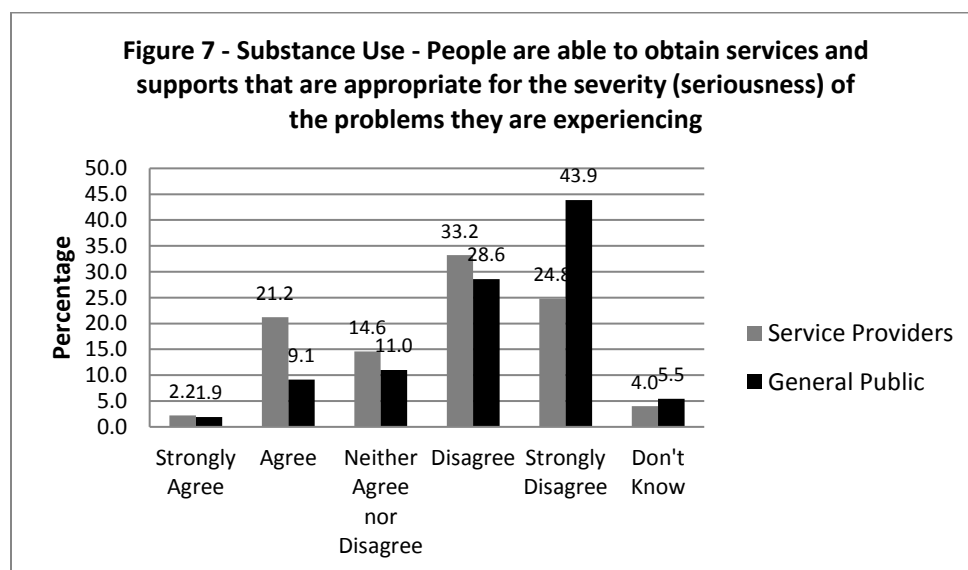
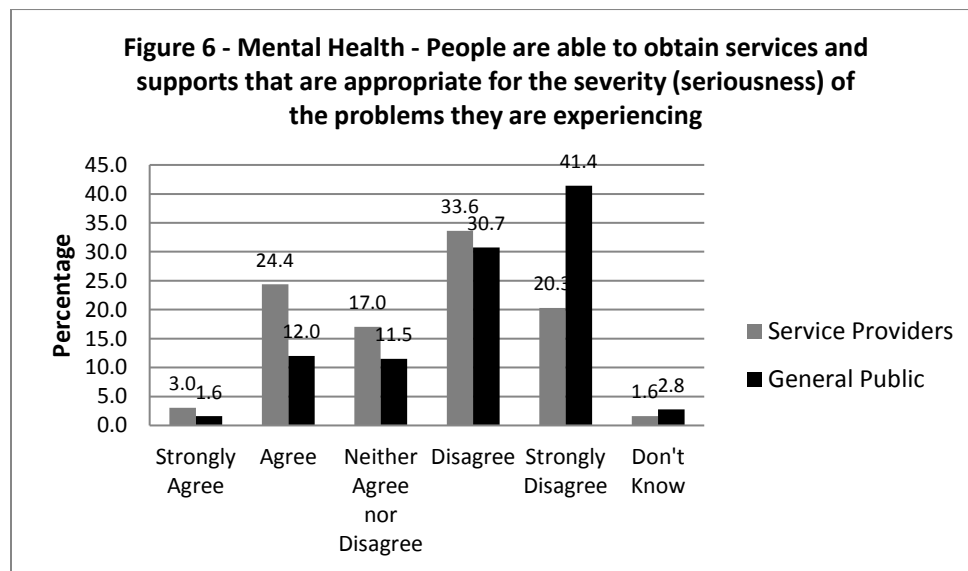
With respect to the items grouped under “Accessibility”, the item with the most positive endorsement concerned availability and accessibility of information about services. That said, still about a third of the general public disagreed with this item for mental health services. The remaining items asking about difficulty accessing services, delays and wait times, and location from home, all received a disagree or strongly disagree response by 65%, with few clear differences between the two groups of respondents. See, for example Figures 4 and 5 below for responses to the question about delays and wait time for treatment and for mental health services and substance use/addiction services, respectively.



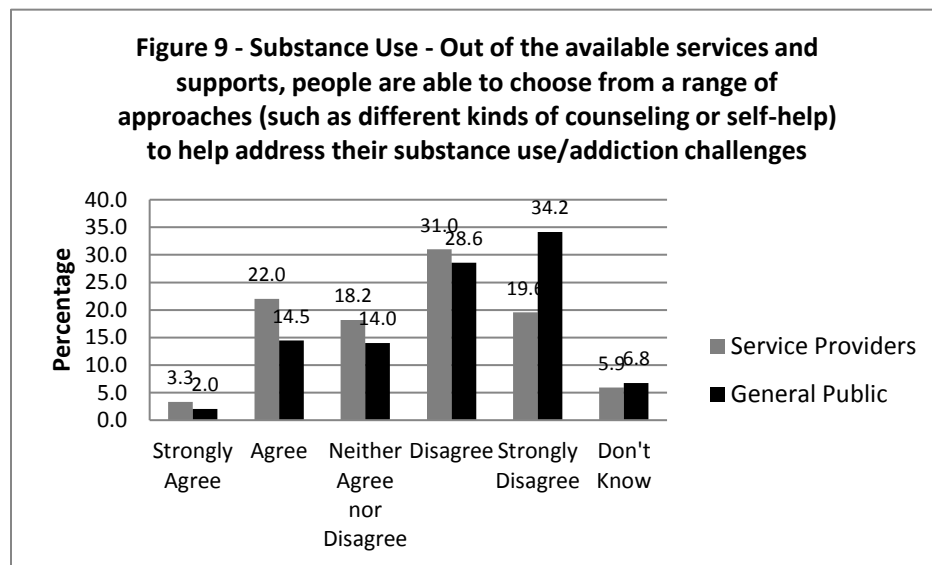
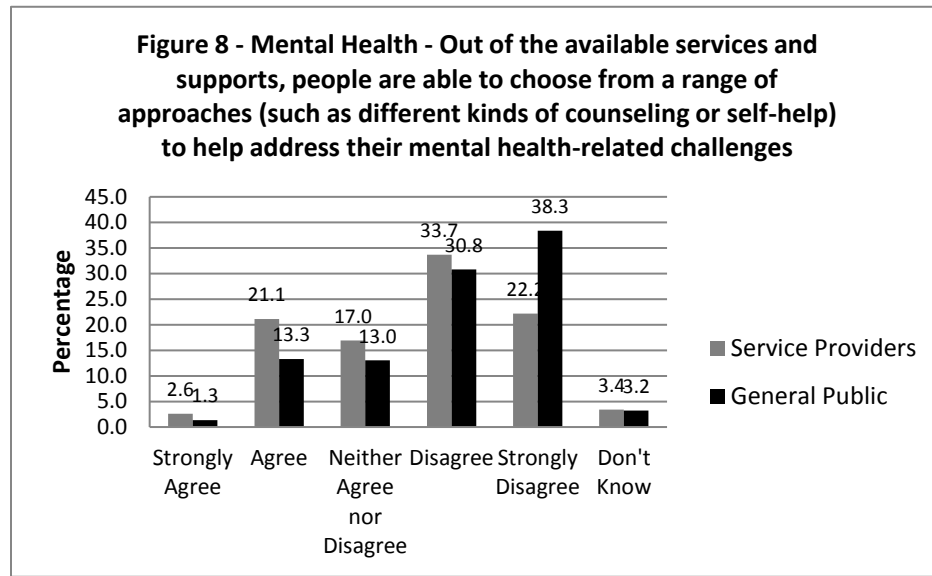
Over 50% of service providers disagreed or strongly disagreed that services and supports were available on days or times of service that fit with people’s schedules. Based on the pattern of the other responses, one would expect a higher level of disagreement among the general public if this item had not inadvertently been omitted in their on-line questionnaire. The levels of

disagreement to the question concerning access to services not limited by language, gender, etc. were heavily influenced by the percentage indicating they did know.

Looking at responses to the items about “Appropriateness”, the responses are somewhat more positive, with the notable exception of the items asking if services available are appropriate to the level of severity or seriousness of the challenge being experienced (also see Figures 6 and 7 below). Level of disagreement was much higher for the general public but still over 50% for service providers. Just over a third of service providers disagreed or strongly disagreed that strong processes are in place for reviewing evidence and making appropriate program enhancements.

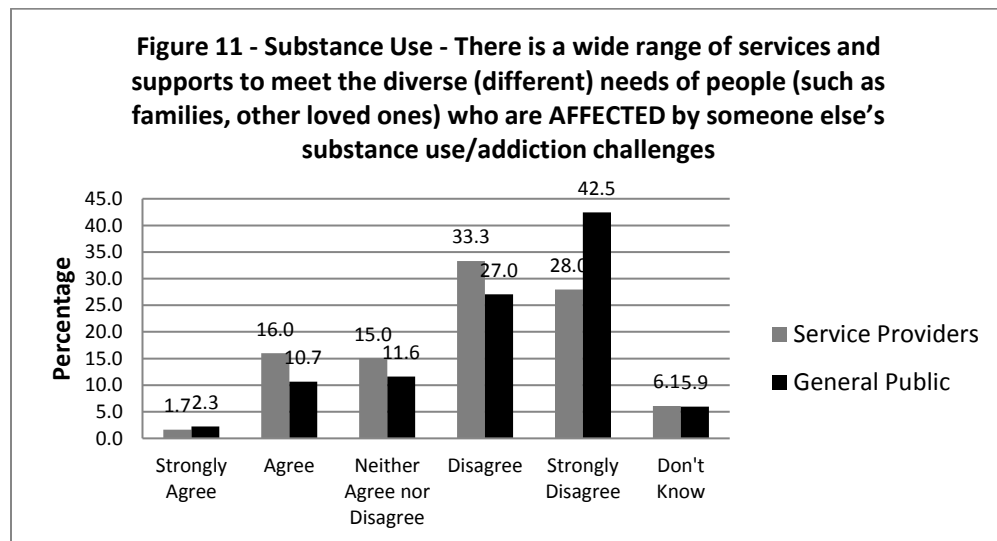
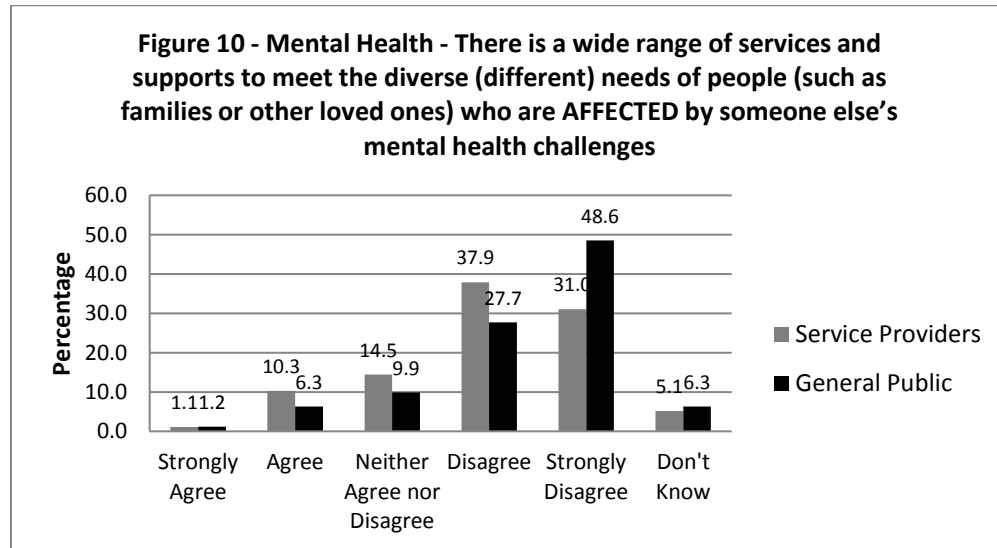


For the items about “Engagement” shown in Table 5, some positive perceptions are coming through to items about explanations being offered for practices being followed and people being able to set their own goals. However, the level of disagreement escalated again for the item concerning people having choice from a range of options or approaches to choose from. See Figures 8 and 9 below.

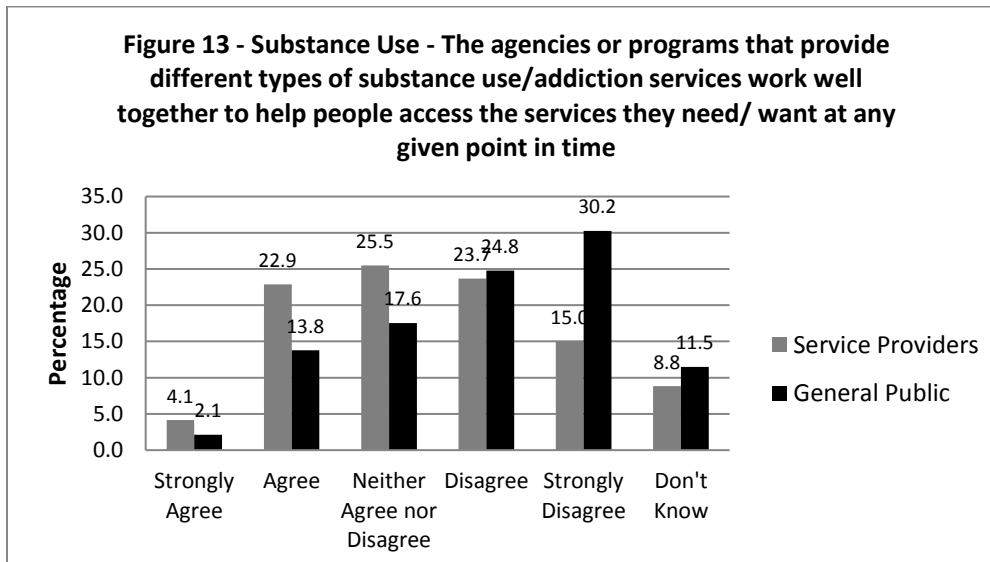
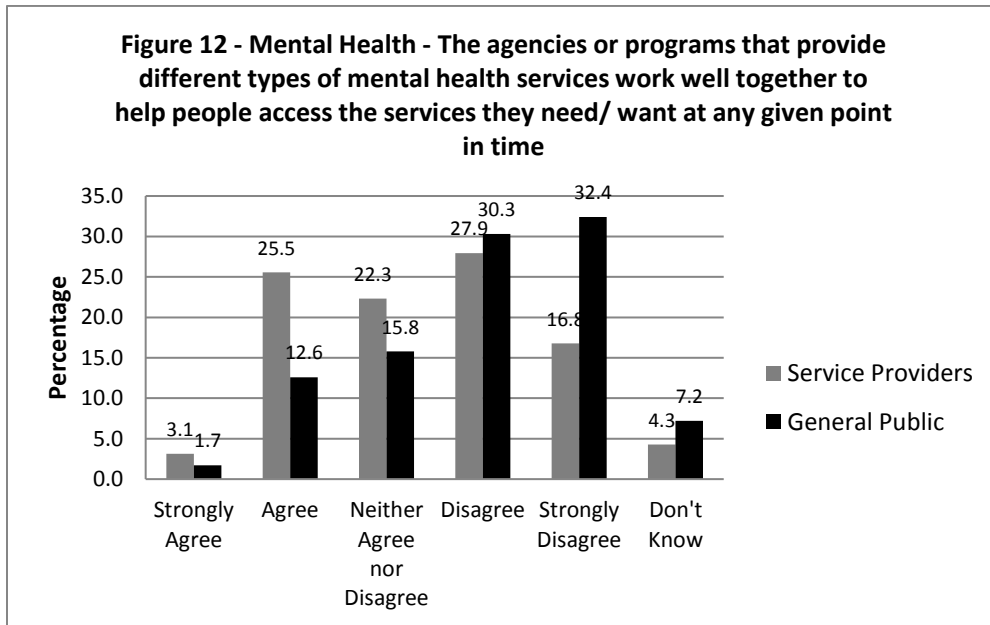


Moving on to the group of items in Table 5 concerning the “Continuum of services”, the most consistent pattern between services providers and the general public with both groups clearly falling on the side of significant disagreement. This included the item on services for people at

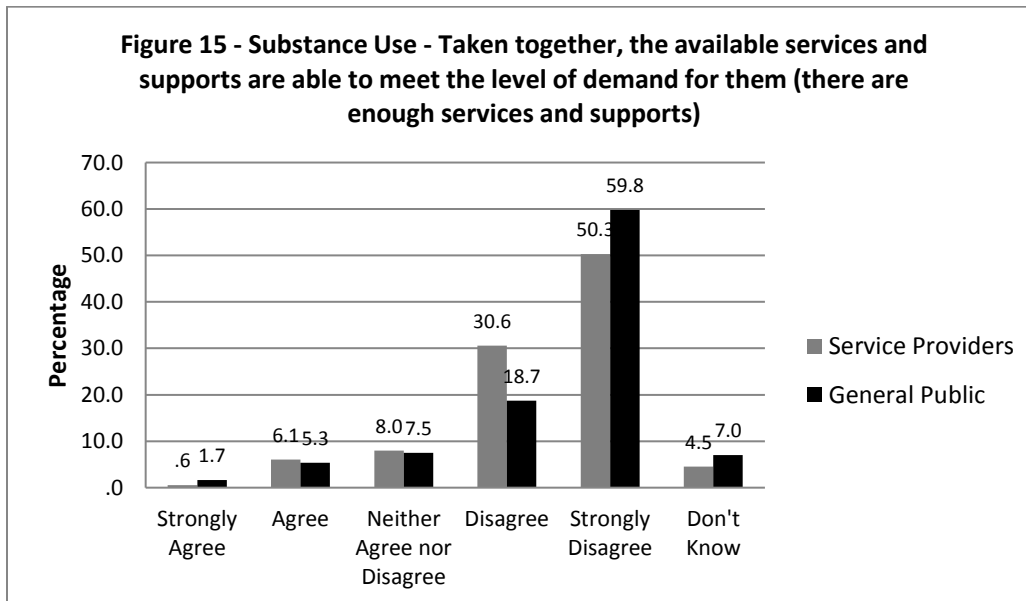
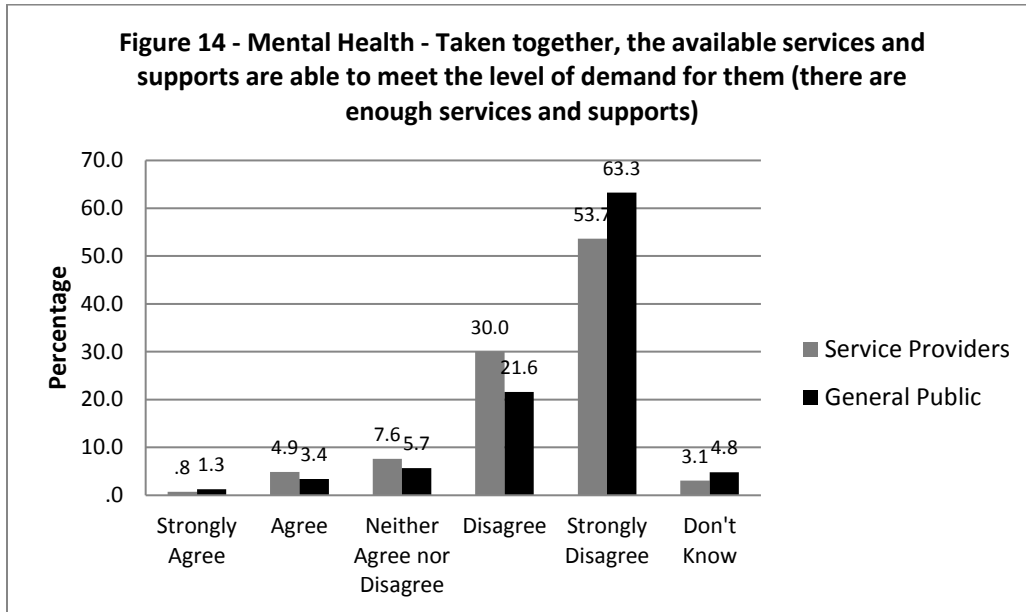
risk of problems, services to meet the diversity of needs of the individual experiencing challenges, and also those affected by someone else’s mental health or substance use/addiction problem. See also Figures 10 and 11 for the responses with respect to availability of services for families and other loved ones affected by mental health or substance use challenges. Clearly, there is a sense that greater availability is needed by both service providers and the general public.



Items related to service coordination seem to have been more challenging for both groups of respondents, as shown by higher responses of “don’t know”. Service providers certainly report being more informed about other services and supports in their region than the general public, which is not unexpected. See Figures 12 and 13 below.



Overall, a resounding level of disagreement was expressed to the item about available services and supports being able to meet the level of demand, with 80 to 85% disagreeing or strongly disagreeing and a high level of concordance between the two groups of respondents (see Figures 14 and 15).



Lastly, the question about overall quality of services was seen much more positively by service providers than the general public, with about 50% of the latter group expressing disagreement with this statement (see Figures 16 and 17). The results were somewhat closer between the two groups for the question about the adaptability of the services and supports to meet changing needs and preferences, with about 50 to 60% of both groups disagreeing or strongly disagreeing. These latter items reflect the impression that respondents are somewhat less concerned with what is available in terms of program content than the actual availability and accessibility of services in relation to needs. That said, 50% of the general public feeling services are not of that high quality is also an important red flag for system planners and funders. A further 10% indicated that they just didn't know, which also speaks to the need for public education.

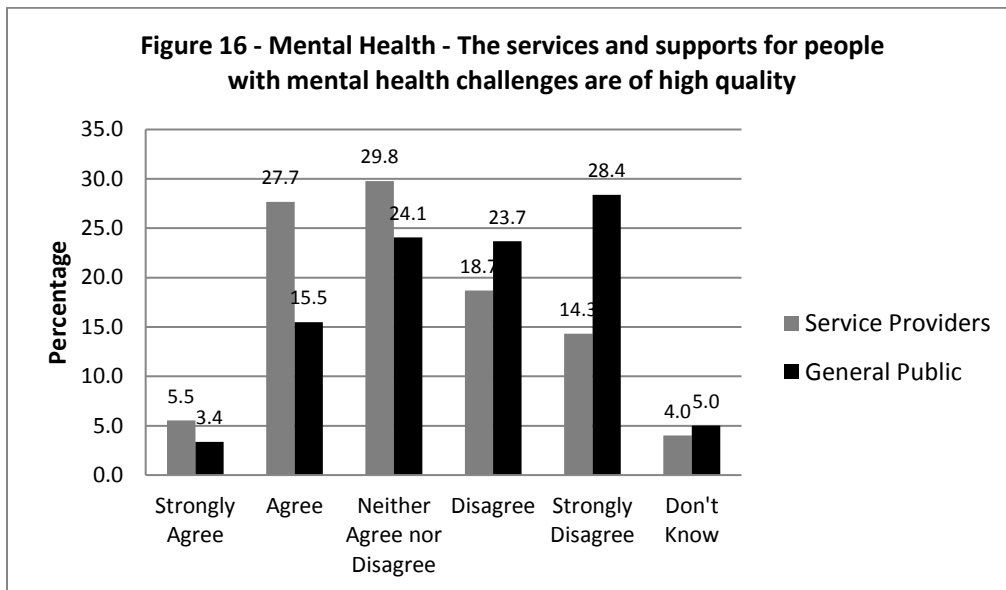
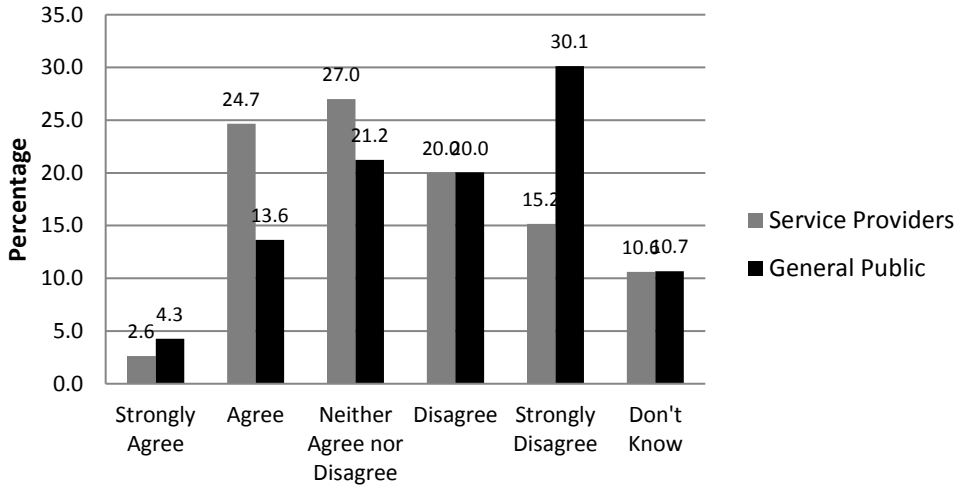


Figure 17 - Substance Use - The services and supports for people with substance use/addiction challenges are of high quality



The following is a brief summary of highlights of the quantitative survey data.

Perceptions regarding access to services: Despite the investment in SUA/MH services and supports as shown in the preceding section, Manitoba's service providers and the general public alike expressed strong opinions about access to these services. This validates findings reported in previous planning processes and documents reviewed and for the first time, based on feedback from such a broad Manitoban constituency. Significant concerns were expressed about lack of information on how to access, the wait times involved, proximity from home, and the lack of flexibility in days and hours of service. Access to services and supports for family members and other loved ones was also seen as very limited.

Perceptions regarding coordination of services: Again, in spite of investments and efforts to create a continuum of services to meet a variety of needs, significant concerns were expressed about the ability of existing services to address the diversity, severity and complexity of people's needs. Significant concerns were also expressed about the extent to which the services are coordinated and support people's transitions across different services, again validating information from several previous planning processes.

Perceptions regarding program content and quality: The perceptions of the quality or current services was somewhat more positive than perceptions of access and coordination, although there were still concerns expressed about the lack of adaptability and flexibility, as well as limited choice. About half of the members of the general public that responded, and about a third of service providers, expressed a concern about the overall quality of services. This suggests that there is considerable room for improvement despite all the efforts and investments that have been made to date.

Perceptions regarding capacity in relation to need: Overwhelmingly, service providers and the general public alike expressed significant concerns that the available services and supports are not able to meet current demand. This underscores the feedback on wait times and other aspects of accessibility, and perhaps also the concerns expressed about coordination, content and overall quality. In short, a reasonable conclusion is that people are experiencing a system of services and supports that is essentially stretched too thin.

6.2.1.2 Qualitative survey results

In this section we first present strengths and challenges reported for mental health services and supports, followed by the same for SUA services and supports. Within each section of strengths and challenges separate sub-sections report on feedback specifically with respect to strengths and challenges with respect to serving Indigenous people.

6.2.1.2.1 Mental health services and supports

Mental health services and supports - Strengths

Respondents were asked to identify the top three (3) strengths of their community or region of Manitoba for people needing **mental health services and supports**. Due to the high number and overlap of responses, only the first strength identified by each respondent was used in the thematic analysis. A total of 1346 respondents (738 GP⁹⁰, 608 SP⁹¹) identified at least one strength in response to this question. The following is a summary of the major themes, beginning with the most frequently identified.

"I believe that a strength of the Winnipeg mental health system is the crisis services. With the addition of the CRC [Crisis Response Centre], there are now many options for immediate service for those in a mental health crisis."

- **Access/availability of services** (687; 385 GP, 302 SP) – over 50% of those who responded to this question identified access to, and availability of, services as a key strength in their community or region. Specific themes included:
 - **Access/availability of specific types of services** – the most frequently identified were:
 - Crisis services (115) - including crisis help lines, the Crisis Response Centre and the Crisis Stabilization Unit, mobile crisis
 - Peer support/self-help; Self-help organizations (29)
 - Community/not-for-profit agencies (25)
 - Inpatient services (23)
 - AFM (22)
 - Intake/assessment services, including centralized intake services (21)
 - Primary care services (17)
 - Community mental health workers (17)
 - Counselling (14)

⁹⁰ General public

⁹¹ Service providers

- ER services (14)
 - School based services (including AFM services; 11)
- **Service providers** (263; 141 GP, 122 SP) – a range of different service providers were commonly described as “compassionate”, “dedicated”, “knowledgeable”, “experienced”, “competent” and “caring” (*“Most mental health care professionals tend to be good at what they do”; “Service providers work diligently to meet the variety of needs presenting to them”*). A small number of respondents highlighted the ability of service providers to deliver quality services in the face of the demands placed on them as a result of serving clients with complex needs (*“Those employees working in the system are very committed and do what they can within resources available”*).
- **Quality of services** (89; 40 GP, 49 SP) – including the delivery of evidence based, client centred, flexible and individualized services (*“strong mental health services available throughout this part of the province”; “constantly evolving and improving”; “a relatively new development of a broader range of holistic services that support good mental health such as free yoga”*).
- **Collaboration/Coordination** (84; 24 GP, 60 SP) – respondents identified collaboration between service providers, both within and outside the mental health sector, and particularly as it relates to connecting individuals to needed care (*“relationships between service providers across agencies mean that liaison and connecting clients is easier”; “CFS agencies work very hard to help youth get services”*). Respondents also frequently identified team-based care as a strength, including shared care models (*“having some counsellors/mental health care placed inside doctors’ clinics is progressive and helpful”*).
- **Low/no cost of services** (36; 23 GP, 13 SP) – respondents valued that individuals with mental health and substance use/ addiction issues were not required to pay for many services, including some community-based, not-for-profit services (*“once identified and properly assessed it doesn't come out of the pocket of the individual”*).
- **Increased awareness/less stigma** (34; 22 GP, 12 SP) – decreased stigma around mental health issues was attributed to increased efforts to raise awareness in the general public and amongst service providers (*“There is a lot of work being done to end the stigma/encourage conversation re: mental illness and addiction”*).
- **Community/family members** (32, 17 GP, 15 SP) – respondents identified strengths and supports from community members, leaders, faith-based organizations, and family members (*“Small, cohesive population groups invested in one another’s well-being”; “there is a strong community spirit, that if the needs and issues can be presented well, community people will step up and do what they can to help”*).
- **Timely access** (29, 13 GP, 16 SP) – respondents identified timely access to supports in general, or to specific services (e.g., intake and crisis supports).

- **Proximity of services** (26; 14 GP, 12 SP) – Respondents identified value in having local access to services in their communities
- **Increased acknowledgement of the need for services** (22, 12 GP, 10 SP) – including the prevalence and impacts of mental health issues (*“There is a growing awareness of the severity of the mental health problems facing young adults”*) and the need to prioritize and strategize, at a leadership level, to address this need (*“Government finally recognizing that access to Mental Health and Addiction services do not come close to meeting demand”*; *“the province is beginning to focus more on the topic of mental health”*)
- **Provision of culturally based/sensitive services** (21; 9 GP, 12 SP) – (*“caters to diverse cultural needs”*; *“culturally aware staff”*).
- **Information sharing/promotion of services** (21; 16 GP, 5 SP) – including printed and web-based materials, that helps individuals and service providers get connected to services.
- **Hours of availability** (16; 8 GP, 8 SP) – a small number of respondents voiced appreciation for 24/7 access to crisis services
- **Capacity building** (14; 5 GP, 9 SP) –efforts to increase the capacity of providers, both within and outside of the mental health and substance use sectors, to better meet client needs (*“more education at the school level for upcoming service providers re: mental health”*)

Mental health services and supports – Strengths for Indigenous populations

Respondents were asked to identify the major strengths, in their community or region of Manitoba, with respect to the provision of mental health services and supports for Indigenous people. A total of 679 individuals provided a response to this question (455 GP; 224 SP). The most common themes are summarized below.

- **Availability of services** (229; 164 GP, 65 SP) - by far, the most commonly identified strength was the general availability of resources (though many respondents did qualify that there were still limits to access (e.g., most specialized services are only available in Winnipeg; gaps in the continuum). Several respondents also identified specific services as a strength – the most frequent being crisis services.

- **Cultural sensitivity/availability of Indigenous-specific programming** (119; 60 PWLE, 59 SPs) – respondents frequently identified the provision of culturally-sensitive services and Indigenous-specific programming as a strength (“*Some excellent facilities and culturally appropriate programs*”; “*specific staff and programs to address cultural needs. Frequent engagement in cultural practices within and outside of the facility.*”). A significant proportion of respondents also noted a general improvement with respect to cultural sensitivity/specific programming (“*Indigenous traditions and practices are becoming more widely accepted and provided*”)
- **Service providers** (84; 53 GP, 31 SP) – respondents most frequently described service providers as “*compassionate*”, “*caring*”, “*knowledgeable*”, “*competent*”, and “*committed*”. A small number of respondents highlighted the strength of the services provided in the face of significant resource and funding challenges (“*Professionalism of workers struggling with insufficient funding*”)
- **Acknowledgement/awareness of Indigenous-specific needs/issues** (70; 55 GP, 15 SP) – respondents saw increased acknowledgement/awareness in many parts of the service system, including amongst leaders (“*Manitoba is finally beginning to work with indigenous people to create programs to better suit the needs for the indigenous population*”), and the general public (“*public's will for change*”). As with cultural sensitivity, a large proportion of respondents noted that this awareness/acknowledgement represents an improvement from the past; though a small number of respondents seeing it still in the early stages (“*We're beginning to realize how desperately changes need to be made.*”)
- **Quality of services** (46; 27 GP, 19 SP) – several respondents identified the general quality of services; others noted specific aspects of strength (e.g., “*client-centred*”, “*welcoming*”, “*evidence-based*”).
- **Points of access** (56; 39 GP, 17 SPs) – Stakeholders described strengths that facilitated initial access into services, including:

 - Availability of information/advertising about services, and visibility of services (11)
 - Location of services (10)
 - Equitable access (10)
 - Ease of access (8)
 - Efficient and effective intake processes (8) - e.g., “*24/7 phone portal*”; primary care physicians as first point of contact, outreach efforts)
 - Supports for access (6) - e.g., translation services

“I believe that clinicians are becoming more informed about Indigenous issues.”

“There are some dedicated people doing their best with very limited resources”

- Smooth transitions between services (4)
- **Availability of Indigenous service providers** (26; 17 GP, 9 SP) – respondents specifically identified the value of Indigenous people providing culturally-specific services (*“There are Indigenous people working in the field of mental health (so there are 'inroads' into the Indigenous communities, and better understanding of their cultures)”*)
- **Collaboration** (21; 5 GP, 16 SP) – general collaboration was identified as a strength; specific examples included collaboration between service providers (*“Organizations are improving how they work together with indigenous people”*), and with Indigenous communities (*“willingness of RHA to work with Indigenous people”*)
- **Strengths of Indigenous people and communities** (20; 14 GP, 6 SP) – respondents identified

“I believe our strengths come from working together in all communities. I strongly believe in many First Nations healing models and believe that they can have a positive impact on our mental health system. In separating us we divide our ideas and our opportunities. We need to work together. Our biggest strength is when we become one and practice many different mental health strategies.”

Indigenous culture, supportive communities, supportive families, and resilience amongst individuals as particular strengths. One self-identified non-Indigenous respondent argued that this strength was a boon to the larger system (*“I believe our strengths come from working together in all communities. I strongly believe in many First Nations healing models and believe that they can have a positive impact on our mental health system. In separating us we divide our ideas and our opportunities we need to work together. Our biggest strength is when we become one and practice many different mental health strategies.”*)

- **Prioritization of Indigenous populations** (20; 16 GP, 4 SP) – some respondents perceived greater availability of/access to services for Indigenous people in relation to the general population. While noted in response to questions about strengths in the system, some of the respondent’s statements suggested that this perception of prioritization was not necessarily considered a strength (*“Greater than average percentage of support to minority population”*; *“there are far more programs available for indigenous people just because of their ethnicity.”*)
 - An additional seven GP respondents explicitly expressed the perception that this prioritization was not equitable (*“We spend too much time catering to different cultures and races, we need to be making sure that everyone has access regardless of who they are and where they live.”*)
- **No/low cost of services** (11; 10 GP, 1 SP)
- **Supports to service providers** (6 SP) – A small number of service providers identified the specific supports available to service providers (e.g., training, education) as a strength

Mental health services and supports – Challenges

Respondents were asked to identify the top three (3) challenges of their community or region of Manitoba for people needing mental health services and supports. Due to the high number and overlap of responses, only the first challenge identified by each respondent was used in the thematic analysis. A total of 1837 respondents (1099 GP, 737 SP) provided a response to this question. The following is a summary of the major themes, beginning with the most frequently identified:

“Nothing for autistic adults (I have spent months and months and months begging for help from the people who are supposed to be there to help; they promise to be there and to help, and then they just kind of fade away saying things like the next person I get referred to will help, and how hard it is to find people here who can work with someone like me); it feels as though I am seen as less-than; they don't care; multiple psychiatrists have labelled me as high-risk for suicide, but that doesn't seem to be enough to get help because I am autistic.”

- **Access/availability of services** (1109; 647 GP, 462 SP) – Over 50% of those who provided a response to this question identified limited access/availability of services as a key challenge. Specific themes included:
 - **Long waits to access services** (356; 216 GP, 140 SP)
 - **Availability of local services** (118; 59 GP, 59 SP) – respondents identified the challenges of delivering local services due to a relatively small population spread across a geographic expanse (*“Large geographical area, with small pockets of population”*; *“Too big of an area for too few people to cover”*). Respondents identified that services tend to be centralized in urban areas resulting, in particular access challenges for rural, remote and northern communities (*“Supports and services are too centralized, access shouldn't require going to a single location. Need local community access”*).
 - **Specific gaps in the continuum of services** - the most commonly identified:
 - Services for children and adolescents, including transition age youth (61)
 - Psychiatry (54)
 - Psychosocial counselling (53)
 - Inpatient treatment beds (48)
 - Addiction/co-occurring SUA/MH services (46)
 - Prevention/early detection (34)
 - Crisis services (26)
 - Services for individuals with intellectual/behavioural challenges (24)
 - Services for low to moderate mental health concerns (19)
 - Follow up supports (19)
 - Family supports (18)
 - Housing (17)

- Psychology (16)
 - Diagnostic/assessment (13)
 - WMS (12)
 - Intake/screening (11)
 - Services for the elderly (11)
 - Services for individuals with eating disorders (9)
- **Workforce** (190; 117 GP, 73 SP) – respondents identified a number of different concerns related to the workforce, the most common being the general shortage of health human resources (*“The level of need is so high, there's not enough providers to meet the demand”*) and the shortage of highly trained, experienced providers in particular (*“difficulty attracting and retaining qualified staff”*). Respondents also commonly voiced concerns about the competencies of mental health providers, particularly amongst primary care providers (*“increasing primary care provider competency around mental illness in young people”; “Local medical staff not knowledgeable enough to handle specific cases”*). The high demand placed on service providers because of supply challenges was also identified. Finally, a small number of respondents identified the need for more cultural diversity represented in the workforce (*“The face of First Nations peoples [is] not represented in the Mental Health workplace”*)
- **Funding/cost of services** (154; 97 GP, 57 SP) – respondents identified concerns either with the lack of funding available for mental health services (*“Grossly underfunded system to meet the demand and volume of the population”*) or the limited amount of services available at no cost to the public (*“It would be a challenge to get the needed help if you were not on a company medical plan”; “Psychology is not funded by the province. Majority of psychologists are private practice and after private insurance coverage ends, patients are paying out of pocket.”*)
- **Quality** (99; 67 GP, 32 SP) – In addition to general concerns about quality, effectiveness and the evidence-base of services, respondents identified the need for more options and diversity in the treatment modalities available to clients (*“One size fits all approach - not enough variety of services”*), with several specifically concerned with the pervasiveness of the medical model (*“Mental health is an individual challenge that does not fit the single medical model”*). Respondents also identified that services were not sufficiently client-centred (*“Many do not listen to the patient (little respect for other stakeholder's opinions, dignity of risk and choice ignored); “The process into and through the system presents as very scripted and not client driven.”*). Finally, a small number of respondents felt that more intensive services are needed to meet the needs

“Good people are tired and burned out and feel hopeless working in a system that continues not to support individuals to get the care they need. Caseloads are too big and wait lists too long”

of individuals with mental health problems (*“Lack of focused and substantial therapy for patients while in psychiatric wards”*)

- **Navigation/awareness of services** (75; 58 GP, 17 SP) – There was general concern that the general public, people with mental health issues, and service providers find it difficult to get information regarding the availability of services and how to navigate them (*“Very difficult to find services, unless you are in a crisis”; “GPs [are] unaware of where to send people”*).
- **Collaboration/coordination of services** (68; 33 GP, 35 SP) – respondents voiced concerns regarding the lack of collaboration and communication between agencies and services to deliver coordinated and continuous care (*“lack of professional cooperation across and within disciplines and within the public and private providers”*); particularly the mental health and substance use sectors (*“No relationship between Community Mental Health and Addictions services”*).
- **Focusing on the social determinants of health** (58; 23 GP, 35 SP) – The most commonly identified areas of concern were a lack of affordable housing, followed by transportation, poverty, isolation, employment and income supports, and recreational opportunities (*“systemic poverty breeds instability; i.e., coming out of successful treatment, many people have no choice but to re enter old life due to lack of housing, employment opportunities”; “Growing income inequality is insidiously dangerous to all. EIA rates need to increase so people are not getting into underground economies (drug, sex trade, panhandling etc.) to supplement their needs.”*).
- **Stigma** (39; 24 GP, 15 SP) – respondents identified that stigma around mental health issues is still common, including amongst mental health service providers, most notably in emergency department settings (*“sitting in waiting room at emergency for hours on end because not taken seriously”*).
- **Inflexible/rigid criteria to access services** (39; 22 GP, 17 SP) – The most common concern in this area was the limited hours available to those in need to access services (*“Walk in options should be available for young individuals experiencing a crisis - if they can't get in when they need services, they tend to not pursue them, resulting in a worsening of their condition. It becomes an endless cycle”; “there but not there, at 5 pm, all doors locked and what if a person is not done talking? It is not a job that cares for the individual”*). Respondents also commonly described rigid entrance criteria that serve as a barrier to accessing services, with some suggesting this was a result of insufficient supply to meet the demand for care (*“It seems like intake turns people away regardless of whether or not they want to access services. It is as though they find a way to reduce their clientele.”; “There are not enough supports for everyone who needs them, leading to rigid eligibility criteria and expectations.”*).

“Navigating the system is difficult for people who are mentally sound. Imagine what it's like for someone who has mental illness.”

- **Cultural sensitivity/appropriateness of services** (29; 10 GP, 19 SP) – respondents identified a number of related concerns in this area, including a lack of cultural competency amongst service providers, a lack of culturally appropriate/specific resources, particularly for Indigenous clients, and racism experienced in the system (*“Racist attitudes towards Indigenous people when entering the emergency department and psychiatric unit”*).
- **Barriers to access** (21; 6 GP, 15 SP) – most commonly, the lack of services available in languages other than English – particularly Indigenous and French. Less commonly identified barriers included bureaucracy, the inability to self-refer to services, and the limited use of technology to increase access to services (*“Many families don't have access to using a phone as they mostly have only texting abilities on their phones. MH services can not communicate with persons in any other way. This limits the families”*)
- **Public awareness/education** (15; 11 GP, 4 SP) – respondents recommended that education and media campaigns directed to the general public is needed to increase awareness of mental health issues (*“More dialogue through media, presentations, speakers, awareness campaigns”*).
- **Engagement** (8; 5 GP, 3 SP) – A small number of respondents identified challenges in engaging individuals with mental health (and substance use) problems with supports and services (*“those with mental health issues will often suffer in silence”*; *“engaging young clients and keeping them engaged in services”*)
- **Criminalization of mental health/substance use** (7; 5 GP, 2 SP) – A small number of respondents raised concerns that mental health and substance use issues are being addressed inappropriately in the criminal justice system (*“addictions and drug use is criminalized, leading to legal issues and jail time for people that are not violent. Prevents rehabilitation”*)
- **Insufficient physical infrastructure/space** (7; 6 GP, 1 SP) – (*“overcrowding”*; *“insufficient facilities”*)

“Far too many mental health patients with addictions problems [are] imprisoned through the court system.”

Mental health services and supports – Challenges for Indigenous populations

Respondents were asked to identify the major challenges, in their community or region of Manitoba, with respect to the provision of mental health services and supports for Indigenous people. A total of 1441 individuals provided a response to this question (764 GP; 677 SP). The most common themes are summarized below.

- **General lack of services** (264; 146 GP, 118 SP) – the most frequently identified concern was a general lack of services available for this population.

- **Lack of locally available services** (220; 110 GP, 110 SP) – respondents identified concerns related to individuals needing to travel outside of their communities to access services, particularly in rural, remote, and northern communities, as well as on reserves. Related to this, several respondents identified concerns with services being centralized in major urban centres, particularly Winnipeg and Brandon (*“Location of services in Winnipeg a double-edged situation”; “Rural MB is not just Brandon and Winnipeg. People need help in their hometowns or near to it.”*)
- **Cultural appropriateness/sensitivity** (200; 85 GP, 115 SP) – Respondents most frequently identified concerns related to:
 - the lack of cultural based services (*“not based on a cultured approach”; “Systems are still based on Western values and do not always work well with an indigenous worldview”*)
 - lack of knowledge/awareness/sensitivity to cultural issues/needs (*“Mainstream/clinical misrepresentation and misunderstanding of the spiritual/knowledges”; “lack of cultural training and knowledge”*)
 - need for language supports (*“services in their language of choice”*), including availability of services in French
 - need for cultural safety (*“Lack cultural safety in accessing services”; “many in the Indigenous community do not feel safe with mainstream mental health services”*)
- **Wait times** (198; 104 GP, 94 SP) – A significant number of survey respondents highlighted concerns with waits to access services in general. A small number described the negative impacts of this waiting (*“Lack of timely access to service leaves too many people coping on their own, with increased risk for crisis including harm and suicide”; “dangerous”; “You need to have a break down or suicide attempt and get put in a psych ward to get any help”*).
- **Workforce** (153; 76 PWLE, 77 SP) – The most frequently identified concerns related to the workforce were:
 - Lack of Indigenous representation in the workforce (*“Not enough cultural diversity amongst Mental Health Services staff”; “Not enough Indigenous workers that can relate to their issues”*)
 - General shortage of clinicians (*“More workers needed in rural Manitoba”; “There are not enough qualified clinicians to meet all the needs which continue to grow”*)
 - Lack of supports available to workforce, including training and development (*“No proper training invested in the North”*)
 - Concerns related to competencies/experience (*“mental health workers are not educated or experienced”; “Not many people up here are that good at their job - including trainers”*)

- **Specific gaps in the continuum of care** (126; 48 GP, 78 SP) – the most frequently identified:
 - Addiction services (20)
 - Counselling (17)
 - Inpatient beds (16)
 - Psychiatry (12)
 - Peer support (12)
 - Psychology (11)
 - Intake/assessment/diagnosis services (10)
 - Crisis (9)
 - Trauma (7)
 - Medical (5)
 - Elders/spiritual care (5)
 - Peer support (12)
 - Peer support (12; 4 PWLE, 7 SPs)
- **Social determinants of health** (118; 49 GP, 69 SP) – the most common concern identified was transportation issues, followed by lack of housing, poverty (*“Third World conditions”*), and intergenerational trauma/colonialism (*“profound widespread damages of residential school system, intergenerational trauma”*). Respondents identified these social determinants as foundational to mental health (*“root issues”*)
- **General access challenges** (98; 53 GP, 45 SP)
- **Collaboration/coordination** (92; 37 GP, 55 SP) – In addition to general concerns related to collaboration/coordination, respondents most frequently identified specific concerns related to jurisdictions barriers that impede the delivery of services, and lack of coordination to ensure continuity of care and follow up supports
- **Challenges related to navigating services** (76; 51 GP, 25 SP) – respondents described *“confusion”* regarding how to access services, as well as a general lack of knowledge/information regarding what services are available
- **Racism and discrimination** (74; 40 GP, 34 SP) – (*“Racism is so common amongst health care workers from all departments”; “institutional racism”; “Systemic racism leading to continued discrimination against Indigenous people and exacerbation of existing mental health issues”*)
- **Need for recovery-oriented services** (66; 42 GP, 24 SP) – the most common examples provided regarding the need for recovery-oriented services was the need for more compassionate care (*“No compassion, no thoughts of the real issues”*), more variety and choice (*“often clients say all treatment centers etc. are the same”*), longer-term services (*“Services are short term but issues tend to be severe”*), and holistic approaches to care (*“The use of medications seems to be the focus of dealing with mental health issues rather than the underlying causes”*).

- **Rules of engagement** (64; 29 GP, 35 SP) – respondents described various barriers to access – most commonly narrow eligibility criteria (*“program focus on who is excluded (mandate) vs how can we help”*), more flexible hours of service (*“mental health is not 9 to 5”*), and other rules of engagement that are seen to impede engagement with services (*“too many hoops to jump to get help”; “if client misses appointments or has difficulty getting to appointments they don't get services”*)
- **Funding/funding models** (66; 31 GP, 35 SP)
- **Lack of services for specific populations** (62; 33 GP, 29 SP) – the most commonly identified were:
 - Youth (28)
 - Individuals with intellectual disabilities (9)
 - Families (7)
 - Vulnerable individuals/individuals with complex needs (6)
 - Older adults (4)
- **Costs to access services** (46; 30 GP, 16 SP) – most respondents identified general concerns with costs associated with mental health and substance use/addiction services and supports. A smaller but significant proportion of respondents specifically identified concerns that psychological services are not publicly funded and available.
- **Engagement** (44; 26 GP, 18 SP) – Respondents identified challenges associated with engaging Indigenous populations in treatment services. The majority of these respondents placed the onus on engagement on the individual with mental health and/or substance use/addiction concerns (*“There is no way to help someone who is clearly in distress, if the person chooses not to utilise the service.”*)
- **Quality of services** (36; 10 GP, 16 SP) – the most frequently identified concern related to quality was the need for evidence-based services. (*“Lack of quality and evidence-based practice”; “to get current with mental health treatments”*)
- **Stigma** (33; 16GP, 17 SP) – (*“people don't want to get involved, they tend to look the other way pertaining to mental health issues”*)
- **Need for more prevention/earlier intervention** (24; 8 GP, 16 SP) – respondents described the system as being structured around acutely affected individuals, at the expense of those whose problem may be more mild-to-moderate, but who are at risk of developing more severe issues in the absence of supports (*“we are in crisis management”; “Finding someone to see the mental health struggle BEFORE the addiction”*)

“[The] current strategy is reactive, and it does not look at or address the root causes; not looking 'up-stream””
- **Concerns regarding the focus on Indigenous populations** (18; 14 GP, 4 SP) – A small proportion of respondents felt that services should be available to all individuals,

regardless of cultural background (“Let’s focus on all people who struggle instead of yet again targeting groups...”; “Too much of a focus on the one group of people.”)

- **Need for more outreach** (17; 10 GP, 7 SP) – Particularly for isolated individuals (“Reaching the people who do not have access to the internet, nor involvement in social groups, or access to regular health care services in general.”)
- **Issues related to privacy** (17; 9 GP, 9 SP) – Respondents identified that individuals from small communities, including those on reserve, are often hesitant to access services due to lack of anonymity (“small communities everyone knows everyone’s business”; “Individuals not wanting to access services in their own communities due to knowing the service providers”)
- **High needs of population** (14; 3 GP 11 SP) – (“not enough services for the mountain of problems we as First Nations face.”)

6.2.1.2.2 Substance use/addiction services and supports

Substance use/addiction services and supports – Strengths

Respondents were asked to identify the top three (3) things strengths of their community or region of Manitoba for people needing substance use/addiction services and supports. Due to the high number and overlap of responses, only the first strength identified by each respondent was used in the thematic analysis. A total of 796 respondents (343 Public, 453 SPs) identified at least one strength in response to this question. The major themes are presented below, beginning with the most frequently identified.

- **Range of services** (482; 212 GP, 270 SP) – Over 50% of all those who provided a response to this question identified the existence of a range of services as a key strength. 55 respondents (19 GP, 36 SP) specifically appreciated the proximity of services. The most common references to specific services included:
 - General services provided by AFM (63)
 - Self-help groups - e.g., AA, NA (41)
 - Culturally appropriate/specific (38)
 - Counselling/outpatient (37)
 - Inpatient/residential (34)
 - Withdrawal management (18)
 - Harm reduction (17)
 - Mental health (14)

“a great multi-disciplinary group working together to figure out how to stretch services to provide access across our region”

- Intake/assessment (13)
- Crisis (13)
- School-based (11)
- Medical (11)
- Opioid replacement therapy (10)
- Peer support (7)
- Family support (7)
- Prevention (7)
- **Quality of services** (67; 27 GP; 40 SP) – in addition to general references to quality, services were described as “client-centred”, “non-judgemental”, “evidence-based”, and “welcoming”.
- **Workforce** (98; 40 GP; 58 SP) – service providers were commonly described as “caring”, “compassionate”, “committed”, and “knowledgeable” (“*staff are very empathetic and understanding while working with a hard client population*”; “*the people who provide the services are kind, nonjudgmental, and want to help*”).
- **Collaboration/Coordination** (47; 10 GP; 37 SP) – different examples of collaboration and coordination were provided, including between AFM and community services and other sectors; efforts to communicate; engagement of families; networking and partnerships; and team-based/integrated services - e.g., between primary care and SUA/MH services; shared care (“*Addiction Network Agencies try to work together to ensure smooth transition [between] what services there are*”; “*AFM youth services works well with multiple agencies to provide services for youth*”).
- **Community/family members** (37; 22 GP, 15 SP) – respondents identified communities in general, as in particular, families (“*[a] healthy family is usually [the] strongest support*”), and grass-roots and community based organizations (“*churches*”; “*Moms Stop the Harm and other groups formed to help identify issues*”). A small number of respondents also highlighted general resiliency as a strength.
- **Acknowledgement of need/advocacy** (27; 13 GP, 14 SP) – respondents identified acknowledgement of the need for services and supports, including within the government (“*government seems committed*”). A small number of respondents identified advocacy as helping with this increased acknowledgement (“*There are many people lobbying government to make an greater investment in addiction treatment*”; “*Vocal community making it known more support needed*”).
- **Promotion/advertising of services** (25; 10 GP, 15 SP) – information about services were said to be well advertised and easily accessed, including online and through printed materials (“*help lines are advertised everywhere*”; “*AFM is well known by service providers and clients alike*”).
- **Capacity building** (18; 7 GP, 11 SP) – the availability of, and appetite for, education amongst service providers; a small number perceived capacity to have increased over time, and others specifically highlighted the CODI initiative.

- **Decreased stigma/awareness** (8; 4 GP, 4 SP) – (“*It is no longer a taboo topic*”)
- **Affordability/low cost of services** (9; 4 GP, 5 SP)

Substance use/addiction services and supports – Strengths for Indigenous populations

Respondents were asked to identify the major strengths, in their community or region of Manitoba, with respect to the provision of substance use/addiction services and supports for Indigenous people. A total of 673 individuals provided a codable response to this question (273 GP; 400 SP). The most common themes are summarized below.

- **Availability of culturally-specific/based services** (132; 39 GP, 93 SP) – the most frequently identified strength was the availability of culturally-specific and/or tailored services. A large proportion of respondents further identified that this strength appears to be increasing in the system (“*Higher emphasis on cultural involvement and elder services in recent years*”; “*More and more culturally sensitive practices in place*”).
- **Services available** (110, 46 GP, 64 SP) – respondents identified the general availability of services as a strength, with several respondents identifying specifically the range and diversity of services available (“*multitude of resources*”; “*diverse options for treatment*”). A smaller number of respondents, while acknowledging the strength of services, also qualified some limitations – for example, the need for more services (“*There are services available, however there are not enough as most of the time persons seeking help are told they will have to wait to get into a program or counsellor*”), and barriers to accessing (“*Once you’re able to access help it’s there!!*”).
- **Specific types of services/agencies identified** (87; 29 GP, 58 SP) – respondents identified the availability of a number of different types of services and/or specific agencies as strengths in the system. The most frequently identified were:
 - Support groups/AA (13)
 - Inpatient/residential addiction treatment facilities (13)
 - Harm reduction services (10)
 - AFM services (5)
 - Medical services (5)
 - Opioid replacement therapy services (5)
 - Family services (4)
- **Awareness and cultural sensitivity** (79; 30 GP, 49 SP) – respondents identified, as a strength, awareness in the system of the needs and challenges faced by Indigenous peoples (“*Understanding struggles of First Nations people in this province*”), as well as the value in culturally-based services in addressing this need (“*Increase awareness and acknowledgement of the importance of culture and traditions*”). Respondents also identified cultural competency and sensitivity as a strength. A small but significant number of these respondents remarked how these

“Indigenous Leaders are doing everything they can to support Indigenous youth”

strengths appear to be increasing (*“awareness and sensitivity appears to be increasing”*; *“There is growing awareness of the need for culturally appropriate programming”*).

- **Service providers** (64; 31 GP, 33 SP) – Service providers were frequently described as *“compassionate”, “committed”, “knowledgeable”, “experienced”* and *“dedicated”*.
- **Quality of services** (46; 9 GP, 37 SP) – respondents identified the quality of the services available as a strength in the system. In addition to general references to quality, some respondents identified services as being client-centred, holistic, effective and evidence-based.
- **Indigenous communities and families** (40; 21 GP, 19 SP) – Several aspects of community involvement were described as strengths, including community resilience (*“Resilient and powerful communities”, “they are resilient survivors in spite of the past and present”*), community leadership (*“outspoken community leaders advocating for services”*; *“Some Indigenous communities are successfully reducing, combating, and healing decades worth of damage from drugs and alcohol”*), and family supports (*“close knit families”*).
- **Collaboration/Coordination** (33; 7 GP, 26 SP) – respondents identified strengths in terms of partnerships, collaboration between and within services, and collaboration between Indigenous and non-Indigenous service providers.
- **Indigenous service providers** (32; 13 GP, 19 SP) – a number of respondents identified the value in substance use/addiction services and supports being provided by Indigenous people. A significant proportion of respondents also valued the services of NNADAP.
- **Access into system** (19; 4 GP, 15 SP) – a smaller number of respondents discussed different aspects of entry into the system as being a strength, particularly with respect to the inclusivity of services (*“Addiction services do not screen people out”*; *“Open door policy”*), and specific supports to reduce barriers to access (e.g., use of tele-health, online support services, medical transport).
- **Low/no cost of services** (18; 11 GP, 7 SP) – (*“Indigenous people get a lot of financial support from the government”*).
- **Cultural competency training available to staff/service providers** (18; 7 GP, 11 SPs) – Various forms of training, including cultural teachings, cultural sensitivity training, workshops and print materials were identified as a strength.
- **Location of services** (16; 8 GP, 8 SP) – A small number of respondents identified the availability of services in their local community as a strength.
- **Marketing of services** (16; 8 GP, 8 SP) – Efforts to market services, e.g., through advertisements, the AFM access line, print materials) were seen as helpful.

Substance use/addiction services and supports – Challenges

Respondents were asked to identify the top three (3) challenges of their community or region of Manitoba for people needing substance use/addiction services and supports. Due to the high number and overlap of responses, only the first challenge identified by each respondent was used in the thematic analysis. A total of 1120 respondents (557 GP, 563 SP) provided a relevant response to this question. The following is a summary of the major themes, beginning with the most frequently identified.

- **Access to services** (760; 361 GP, 399 SP) – the majority of all survey respondents identified limited access/availability of services as a key challenge. The following themes were frequently noted in relation to access/availability: While the majority of respondents noted that the existence of a range of substance use/addiction services was a strength in the system (see above), almost three quarters of respondents noted that access to these services is a key challenge.
 - **Timely access to services** (192; 89 GP, 103 SP) – respondents identified the length of time to access services in general as problematic, and particularly for residential services. Some respondents highlighted the impacts of this wait for people in need (*“Lack of timely access for addictions help- when someone needs help, a 6-month wait is a death sentence”*).
 - **Proximity of services** (119; 54 GP, 65 SP) – respondents identified the need for services in local communities/regions (*“services only available in cities/larger towns. Rural people who are isolated are missed”*).
 - **Gaps in the service continuum** – most commonly:
 - Inpatient/residential services (101) – most respondents referred to this service in general; a small number of respondents identified the need for residential treatment programs that cater to individuals with severe and/or complex addiction issues, particularly for youth
 - Withdrawal management services (WMS) (94) – most respondents referred to gaps in WMS in general; specific gaps identified included medically supported services, mobile/community-based services, and detox services for illicit drug users (e.g., methamphetamines, cocaine)
 - Long-term services (37) – including services for youth (*“I feel that anyone with substance use/addictions cannot be cured in 21-day programs. They need to be in a program for months”*)
 - Mental health/co-occurring disorder programming (19)

“There is no place one can go to detox from cocaine. The establishment says you can't die from withdrawal from cocaine however I have known people that have rather not quit because of withdrawals. This is just a slower way to commit suicide. I have known people that have killed themselves when withdrawing from cocaine. So, don't tell me you can't die from cocaine withdrawal.”

- Culture-based programming (17)
 - Harm reduction services and supports (15)
 - Follow up/after-care supports (14)
 - Opioid replacement therapy (12)
 - Services for women (11) – several of these respondents reported that there is a striking disparity between the availability of services for women compared to for men.
 - Family supports (9)
 - Counselling (9)
 - Medical supports (8)
 - Prevention (7)
 - Supportive/transitional housing (6)
- **Funding for services** (57; 25 GP, 32 SP) – In addition to general concerns about limited funding/funding cuts, respondents were most likely to identify these issues in relation to community-based/not-for-profit agencies
 - **Quality of services provided** (51, 28 GP, 23 SP) – Beyond general concerns about quality, the most common theme related to the perceived emphasis on 12-step/abstinence-based models (“*[need] a shift away from reliance on the 12-step ideology as this only serves the needs of a select group of individuals with addiction issues*”; “*Only AFM <as an option> but lots of people aren't religious*”). Relatedly, some respondents identified the need for more holistic, diverse service options, including individualized supports (“*The assessments are generic and do not truly assess the clients' needs*”). A number of respondents also raised questions about the efficacy/evidence-base of substance use/addiction services and supports.
 - **Collaboration/coordination** (46; 19 GP, 27 SP) – The most common concerns included the need for better integration of mental health and substance use/addiction services and supports (“*Addiction services and MH services should be combined-not separate*”), a range of different types of service providers to work more collaboratively with each other, including with other sectors (“*Silo of Addictions services in MB is a problem, no integration with other health services*”), better continuity of care, including referrals to other services, co-located services, and communication between service providers.
 - **Social determinants of health** (43; 22 GP, 21 SP) – including poverty, poor living and social conditions in communities, lack of transportation, inter-generational trauma, easy access to substances (both on the streets and through physician prescribing practices), and the perceived high level of social acceptance of substance use in general.
 - **Awareness of services/navigation challenges** (34; 23 GP, 11 SP) – Respondents identified that both service providers and the general public either have limited access to information regarding the availability of services, or are faced with challenges in navigating them (“*There is no clear known path for an addict to take once they make the*

decision to stop”; “clarity on where to start the process when you don't have a family physician”).

- **Workforce** (34; 14 GP, 20 SP) – Respondents most commonly identified the short supply of service providers, noting, in particular, the need for qualified staff.
- **Barriers to access** (31; 13 GP, 18 SP) – The most common barrier to access identified related to limited availability of services outside of regular business hours (*“Hours of operation are not when people present with a need. Limited after-hours options.”*). Respondents also identified entrance criteria for programs that are perceived as too restrictive (*“Addictions foundation only deals with very specific types of addictions. All addictions are caused by trauma”*) and concerns related to privacy and confidentiality when accessing services, particularly in small communities.
- **Capacity-building** (28; 15 GP, 13 SP) – Respondents most commonly identified the need for training and supports to service providers, including substance use service providers, family physicians, elders, and hospital staff.
- **High needs** (23; 9 GP, 14 SP)
- **Stigma/awareness of substance use** (22; 17 PWLE, 23 SP) – including amongst service providers and the general public (*“it is around every corner and in every home, in every family, it is still a shame, guilt and judgement issue”*)
- **Cost/affordability of services** – (16; 12 GP, 4 SP)
- **Equity issues** (14; 7 GP; 7 SP) – most commonly, related to the availability of services in different languages, particularly French and Indigenous languages; and the perceived lower quality, funding and availability of services for women, in relation to services for men.
- **Client engagement** (8; 4 GP, 4 SP) – A relatively small number of respondents identified challenges in reaching clients and retaining them in services.
- **Racism** (8; 6 GP, 2 SP)

“People with substance issues or mental health illness are treated horribly. Please ask to sit in on meetings and listen to the way these doctors treat these people, it is horrible. You would never see a cancer patient or a heart care patient or anyone else treated with such utter lack of human decency.”

Substance use/addiction services and supports – Challenges for Indigenous Populations

Respondents were asked to identify the major challenges, in their community or region of Manitoba, with respect to the provision of substance use/addiction services and supports for Indigenous people. A total of 977 individuals provided a relevant response to this question (467 GP; 510 SP). The most common themes are summarized below.

- **General lack of services** (156; 70 GP, 86 SP) – the most common challenge identified by respondents was a general lack of services available, and the resulting inability to meet the demand for supports.
- **Wait times** (135; 55 GP, 80 SP) – respondents identified the need for more timely access to services. Several respondents identified the need for immediate access to engage clients when they are ready for treatment (*“it seems if they are ready to get help they should get it now”*). A small number also discussed the negative impacts of needing to wait for services (*“It is difficult to get clients into detoxification and/or treatment facilities due to the prolonged wait time - this has caused clients to delve into deeper addictions and/or over-dose”*).
- **Lack of local services** (127; 42 GP, 85 SP) – Respondents flagged that because access to local services is limited, particularly in rural, remote and northern regions, clients frequently have to travel long distances to access treatment and supports.
- **Culturally informed services** (117; 36 GP, 81 SP) – respondents identified the need for culturally-based services and, in more mainstream programming, cultural sensitivity and awareness (*“very little traditional based content in curriculum”*; *“More traditional healing”*; *“Most have minimal cultural content”*).
- **Specific gaps in the treatment continuum** (126; 58 GP, 68 SP) – the most commonly identified gaps in the continuum, by far, were detox services (particularly for drugs) and inpatient/residential treatment beds (particularly long-term models of care). Other less commonly identified gaps were outreach, prevention, opioid replacement therapy, harm reduction services, counselling/interventions, medical supports and peer support.

“Saying “residential treatment” does not encourage indigenous clients to participate”
- **Workforce** (97; 48 GP, 49 SP) – the most commonly identified need was for more qualified service providers in general, and more Indigenous service providers in particular. Respondents also identified the need for more training and supports for providers (particularly in the area of cultural competencies) and mechanisms to ensure that staff are accountable to their roles and are compassionate to the people they serve. A small number of respondents also identified the negative impacts on staff related to high caseloads, describing some providers as *“over worked”* and suffering from *“burnout”*.
- **Social determinants of health** (95; 38 GP, 57 SP) – respondents most commonly identified the need to address transportation challenges, poverty, and intergenerational trauma resulting from the legacy of residential schools and colonization (*“Aboriginal people have not had an opportunity to heal the trauma and post-traumatic stress from colonization, the loss of their cultural identity, the loss of the land and the right to be themselves without others telling them what to do”*)

- **Quality** (88; 50 GP, 38 SP) – The most common concerns related to the quality of substance use services was the need for longer-term supports (*“Treatment programs are not long enough to address the strong effects of hard drugs”; “30-day treatment programs only begin to address the problems”*) and the need for more treatment options/models (*“not meeting people where they are in their addiction stage”; “very little for drug addiction...too much on alcohol”*).

“AFM still operates largely from an abstinence-based model that is strongly rooted in the 12-step model, which is very Eurocentric in its practice in this province”

- Respondents also identified the need for more holistic services (*“True involvement with treatment of the whole person - not only providing drug therapy”*), more effective and evidence-based services (*“Residential treatment is expensive and ineffective (up to 95% relapse)”*), and more compassionate, welcoming services.
- **General concerns about access** (65; 32 GP, 33 SP)
 - **Funding** (59; 25 GP, 34 SP) – in addition to general concerns regarding funding, a small number of respondents also identified that the costs attached to accessing some services are a barrier, particularly for marginalized populations (*“not enough free services”; “to get counselling for addictions is expensive and not available for most people without money”*)
 - **Services for special populations** (45; 17 GP, 28 SP) – respondents identified specific gaps in the services for particular populations. The most commonly identified were for youth, particularly for youth with serious drug use who do not have access to long term care; individuals with co-occurring mental health conditions, individuals with drug concerns (e.g., crystal meth, opiates), individuals with cognitive issues, families, and marginalized populations.
 - **Need for collaboration/coordination between services** (43; 20 GP, 23 SP) – respondents identified a number of areas that would benefit from greater collaboration/coordination, including better integration between the mental health and substance use sectors (*“mental health and addiction services need to be merged”*), the need for better communication between services (*“no transfer of information”; “mandates and hiding behind PHIA restrictions as a barrier to shared care/collaborative work”*), jurisdictional boundaries (*“services on reserve are federal and different then provincial initiatives”*), and the need for agencies and communities to come together to ensure that client needs are being met (*“high risk clients could benefit from inter-agency collaboration”; “It is just red tape & referrals to different services to no avail....pass the buck from mental health to addictions to mental health etc. when it is all tied in together & they should all be working together.”*)
 - **Need for follow-up/post-treatment supports** (41; 14 GP, 27 SP) - in addition to the gaps identified above, several respondents also noted a need for follow up supports/services

in clients' communities after they have completed formal treatment services (*"I believe people living on reserves have difficulty adjusting after leaving detox, treatment etc. and going back to their communities because of lack of resources."*)

- **Engagement** (42; 21 GP, 21 SP) – respondents discussed the challenges in engaging individuals in services, including the initial step to each out for help, and retaining them in services.
- **Barriers of engagement** (34; 10 GP, 24 SP) – respondents identified a number of different barriers that limit engagement of individuals into services; the most common being the need for more accessible hours of services (*"addiction is not a 9-5 thing"*). Respondents also described services as "inflexible" – for example, limited tolerance for missed appointments and voluntary service requirements.
- **Racism** (32; 14 GP, 18 SP) – (*"there is systemic racism that goes unacknowledged on a daily basis."*)
- **High needs** (31; 17 GP, 14 SP) – respondents identified the scope of addiction and substance use issues in the province as a significant barrier to being able to respond effectively to need (*"with the growing number of individuals using drugs, there is a huge struggle with accessibility & funding to expand these programs"*).
- **Awareness of services/navigation** (24; 13 GP, 11 SP) – respondents noted that individuals with substance use/addiction issues, service providers, and the public are not always aware of what services are available and how to navigate them (*"we need some kind of a comprehensive list of all available addictions services so that we can help refer our clients to the appropriate place, and for them to be able to help themselves by knowing what's available to them"*). A small number also identified that more education is needed for people to understand the range of options available that are appropriate for different issues (*"There is a feeling from the public that locking people up is the answer, when this is not supported by evidence"*).
- **Stigma associated with substance use** (20; 13 GP, 7 SP) – (*"Being judged as an addict"; "There is still so much stigma around addictions use"*)
- **Concerns regarding the focus on Indigenous populations** (10 GP)– A small proportion of the public felt that services should be available to all individuals, regardless of cultural background (*"The challenge is to help all people with addiction problems regardless of race"*).
- **Language barriers** (15; 2 GP, 12 SP) – respondents identified that the lack of services available in various Indigenous languages can be a barrier to access.

6.2.2 Consultation with stakeholders

6.2.2.1 Broad Systems Approach

Complexity and the need for a population health approach

A strong theme emerged with respect to the increasing complexity of SUA/MH challenges at the individual and community levels. Manitoba was frequently described by stakeholders

“We have seen an increase in clients with crises/psychoses related to meth use; an increase of use among people with no previous psychiatric history.”

providing input into this process as having an “extraordinary problem”. Levels of physical and mental co-morbidity were seen as increasing, typically mixed in with a wide range of social and justice related challenges. Illnesses and related comorbidity connected to Acquired Brain Injury, autism and other neurodevelopmental illnesses, concurrent mental

illness and developmental disability, and health conditions requiring significant pain management were all said to be adding complexity to the work of mental health and substance use/addiction services. This theme resonated for all age groups (children, youth, emerging adults, adults, and older adults); only the nature of the profile changing to some degree, for example, dementia and other cognitive impairments among older adults.

A shift to stronger substances was also noted, in particular, opioids and crystal meth. The increase in deaths associated with opioid use were highlighted by many stakeholders, including people and families with lived experience, many of whom had lost a loved one in tragic but often preventable situations. A significant spike was frequently noted in crystal meth use in all regions, but especially so in the Winnipeg and Prairie Mountain RHAs. Stakeholders also discussed how crystal meth use has negatively affected the stability of their client populations in the last year, and that there has been an increase in crystal meth use amongst individuals with no prior history of problematic substance use. This was said to be putting a strain on the system, including, but not limited to, emergency departments, crisis and stabilization, and inpatient psychiatric services.

“I think we have to be able to differentiate between a population-level strategy and individual strategies and not suggest that one is more important than the other but inextricably linked.”

“Deinstitutionalization really shifted the community mental health system away from dealing with the full spectrum to focus on the most needy, the people left in the dust is the much larger percentage of the population dealing with more moderate level problems.”

Service providers and community members also expressed concern about the availability and ease of access of drugs and alcohol (e.g., from physicians; and, for children and youth, the Internet and parent’s medicine cabinets, and also the impact of advertising). Stakeholders also described how people are getting “creative” (e.g., crushing Gravol, “cooking” opiates out of Tylenol). Some stakeholders also expressed worry that the system is “losing sight” of the impacts of alcohol and marijuana use in the context of the opiate

crisis (e.g., “alcohol is off the radar of public health”) and that drinking and marijuana in particular is becoming normalized among youth. Others also reflected on the proliferation of gambling opportunities and associated risks. “Gambling is there... casinos across the border...many lounges and restaurants”.

In counterpoint to the high and increasing levels of need, the lack of provincial population-based planning was frequently noted. The historical tendency for making system enhancements was described as “being driven more by Ministerial shuffles than a provincial plan”. Improved planning was said to be needed to better account for the unique needs and contexts of the different regions of Manitoba, and to better anticipate and respond to the impacts of emerging or unanticipated population-level changes, for example, the increase in immigration, including refugees; migration of communities in response to natural disasters (e.g., flooding); the opioid and crystal meth crisis; and unknown impacts of the legalization of cannabis. Some stakeholders engaged in provincial planning and policy development noted missed opportunities to be making better use of available data for planning services across the regions, for example, pharmaceutical drug utilization patterns and the extensive data available through the MCHP.

“Resources are unavailable unless you are in crisis, no supports until you’re at your worst.”

In concert with this concern about the lack of a provincial plan, many stakeholders in a service provider or planning role noted the shift that has occurred in provincial focus toward services and supports for those with the highest needs and severity profile. Some framed this as too much emphasis “on the top of the pyramid”. Others framed this in the historical context of deinstitutionalization in the mental health sector which, over time, expanded its initial role in supporting those with severe and enduring mental illness (SMI) to also deliver services to

“We’ve never had an approach that is grounded in population health approach based on pyramid; so, we’ve thrown a bit of money here and there; ok we are going to start shared care but we are going to start in three clinics; then we try to make a case to government to build it over time. That has been the model for building for the last number of years; probably 30+ years”.

people with a wider spectrum of challenges, eventually including a larger role for mental health promotion. This trend, combined with the increased complexity among those at the top of the pyramid, and working with essentially the same base budget or less, was said to have now squeezed resources very, very thin in the delivery of core services. From a system planning perspective, this highlights the imbalance in the level of population need and the distribution of resources. From the perspective of the individuals or family members with lived experience, the current capacity and nature of services available

means that things don’t get addressed until the situation is severe and often in crisis mode.

The population health pyramid was a concept that resonated well with stakeholders who also made a connection to previous planning that created and evaluated demonstration projects but from the outset did not aim for coverage on the basis of the overall level of need in the population.

Regional and population variation in need

Not surprisingly, given the size and diverse nature of the province, stakeholders from virtually every region noted the importance of the variability in regional and local strengths and needs and the importance of this context for population-based planning. In the Northern region, for example, the remote nature of many communities, significant challenges related to transportation, the rapid escalation of opioid addiction, the extremely high rate of suicide (in several communities said to be “*basically once a month*”); and the extremely high cost of medical evacuation for crisis management (only to be returned to very little if anything by way of support) were cited as extremely difficult circumstances in the face of very limited resources. The existence of work camps, many very large in size such, as for the new hydro generating station, was also said to be a unique strain on northern resources.

“Yes, it’s everyone’s business, and everyone needs to own a share”.

In concert with the views reflecting the level and complexity of need, and the call for a population health approach, many stakeholders advocated for a wider multi-sectoral response. Mental health and addiction was seen as being “*everyone’s business*” because it was significantly impacting virtually all sectors. When reflecting on the solid business case for investment, others added that: “*Yes, it’s everyone’s business, and everyone needs to own a share_<emphasis added>*”.

In Prairie Mountain Health (PMH), the previous closure of the Brandon Mental Health Centre, and ensuing work to build strong, well-connected community mental health teams, gave rise to many strengths in the system today, including strong community partnerships. Other

“We have two staff out of Minnedosa community, not sure how big but pretty small, but only 2.5 staff out of Steinbach; and in the last 20 years it has doubled in population. We need more nimble ways in Manitoba to have a health system that responds to population health needs; that we can make more strategic decisions where we have staff”.

challenges in PMH, however, remain, some connected to the size and complexity of the region and others resulting from the previous merger of three health authorities into one, and time needed to smooth out planning and resource allocation based on population needs (which was said to be going reasonably well for mental health services). Stakeholders in the Interlake-Eastern region also noted the size of its geography, and in relation to road travel for staff (second to north but the north being less populated: *“it’s difficult to place mental health workers strategically to cover the entire region; they are located in community health offices and clients have to travel to get to them”.*

Unique regional concerns were also expressed in the Southern region, for example, related to the rapid growth in population and diversity. Regions were also noted as differing widely in urban and rural composition with significant implications for resourcing and siting and sizing of programs due to travel and related cost concerns for community members. This was expressed in the Interlake Eastern region, for example, with Selkirk seen as *“the centre of the universe”* and where most of the resources were located: *“Not everything should be in Selkirk. We need to spread around to address geography challenges”.* Within-region diversity was also noted in Winnipeg with concerns focused on the high needs of particular neighbourhoods (e.g., the North End); needs that were said not to align with resource distribution across the WRHA.

“...for example in AFM, we will have this psychiatrist in Winnipeg, and yet no services in Brandon, or in Thomson. We have a psychologist that goes to the Compass program but no other psychology services for other programs. It needs to tie into what is the model and what are our evidence-based services if we have these cases ... instead we have responses that maybe are historic or maybe it is knee jerk; but definitely in AFM it’s not consistent”.

"They <peers> are impacted by lack of holistic services and struggle with trying to manage addictions and mental health while their basic needs such as safety and adequate housing are not met."

Orienting the system towards a recovery paradigm

The broad theme of “*recovery*” was reflected in several different ways. The first was the importance of re-orienting the system to a new recovery paradigm, consistent with directions in other provinces and countries. The medical model was still seen as the predominant philosophy in service delivery. Related to this was the strong support offered for more peer support options for service delivery in the province, as well as more engagement and support for families. A “recovery orientation” was also said to include increased participation of people with lived experience and family members in system planning. It was also linked to the need for a diverse workforce that included not only peer support but also an important role for proctors/support workers, and emergent “*recovery coaches*” in some addiction services.

“*Providing more client choice*”, in the context of this recovery orientation was also identified. Service providers, people with lived experience, and involved community members consistently identified the need for a range of service options that facilitate client choice (“*treatment options are all the same*”), including where services will be accessed (“*the location of services can be triggering*”; “*everything revolves around nine to five office hours*”). Both internal and external stakeholders⁹² reported concerns that addiction services still place too much emphasis on the 12-step model, and are particularly problematic for youth - “*we are doing more damage*”. While some stakeholders did report seeing a positive shift away from this model in at least some of AFM’s services, greater acceptance of service options along the harm reduction continuum was preferred. Also with respect to addiction services, longer term services, including those for youth, were seen as needed in order to achieve a sustained recovery.

The need for a recovery orientation was also seen as connected to “**dignity of care**” for older adults, for example, removing barriers to being able to age in place.

Support for recovery and the social determinants of health

Stakeholders identified a range of social determinants of health that not only significantly limit the ability to reach individuals with SUA/MH challenges and connect them to appropriate services and supports, but that can further exacerbate these problems. Some stakeholders suggested that these issues need to be addressed with dedicated and accessible funding, either directly through MHSAL and/or through collaborative arrangements with partners.

The most commonly identified issues were:

⁹² The term “Internal” stakeholders refers to those working in government and “external” refers to those consulted who work outside of government.

- Housing – that is safe and adequate (*“people are often being released into homelessness”*). In some cases, this is a function of a lack of adequate housing in general, a reality particularly dire in Indigenous communities. However, housing stock appropriate for a range of housing with support needs of people with mental health and substance use/addiction challenges was said to be *“drying up quickly”* in many parts of the province, particularly several neighbourhoods in Winnipeg. In other cases, individuals face barriers to housing because of their mental health and substance use/addiction challenges. Some stakeholders did identify positive inroads with Manitoba Housing, resulting in more clients being accepted into housing. Transitions from correctional facilities were also said to create challenges with no housing or other supports available.
- Transportation - particularly in rural and remote regions where public transportation is largely absent. (*“We don’t refer people to Thompson because people can’t get there”*). In addition to the financial strain of transportation, stakeholders identified that options for travel are often quite limited (e.g., convoluted journeys, inconvenient travel times, weather conditions) and that it puts undue burden on clients who are already under significant distress. Challenges related to transportation were reportedly compounded by jurisdictional funding barriers and policies for Indigenous clients living on reserve (e.g., requirements to complete treatment for travel costs to be covered and requirements to disclose the reason for travel in order to access funding).
- Income and employment –many stakeholders from the employment service sector identified the increasing number of people moving away from the labour market, as well as the increasing proportion of individuals with mental health and substance use/addiction challenges receiving employment and income assistance (EIA) disability supplements. Income-related issues were, of course, also closely connected to housing and transportation, as well as child care, racism and discrimination and gang involvement (noted below).
- Child care/child-friendly services – that allow caregivers to access services without undue financial hardship and/or prolonged periods of separation from their children. For many stakeholders, this also spoke to the need for family-centred services to be reflected as a core value of the overall system, with a concomitant reduction in separation of families, and an increased focus on the treatment of the whole family.
- Racism and discrimination – experienced, for example, by individuals in lower social economic groups, minority cultural groups and individuals (*“the middle/upper class is treated differently than those receiving Employment and Income Assistance”*). Indigenous people, as well as newcomers and refugees, noted experiences of racism and discrimination as a significant barrier to accessing mental health services, as well as needed supports such as housing and employment. The inappropriate treatment

of people with mental health and substance use /addiction challenges in emergency departments (ED) and other health services was also reflected in the context of racism and discrimination.

- Gang involvement - engaged stakeholders in gang prevention made a strong link to the roots of gang involvement (and youth incarceration) in the social determinants of health, including social conditions such as lack of recreation and employment opportunities, neighborhood characteristics such as high-density housing, and low income, and impacts of historical trauma.

Prevention, Health Promotion and Early Intervention

A key component of a broad systems approach to dealing with access and coordination was said to be prevention, health promotion and early intervention. This included the need for mental health and substance use and addiction to be a major priority within public health.

“We have to look at all the key factors and what makes people choose to use substances that become addictive for them, and how horrible their lives are to make them go there.”

Stakeholders stated that there is a strong business case for investing in these areas, in terms of preventing more significant, distressing, costly and complex concerns in the future (*“there is overwhelming research that prevention and health promotion pays off”; “we have to flip the system upside down a fair bit and focus more on prevention instead of treatment”*). While examples of *“pockets”* of innovation were identified (e.g., *Families First, Strengthening Families, Towards Flourishing, PAX Good Behaviour Game, Mental Health First Aid - First Nations*, some important suicide prevention initiatives), there were concerns that provincial coordination of

“There is still not enough of a consciousness about how do we create resilient families, individuals, leading to resilient communities”

these have been *“inconsistent”*; that these initiatives are not adequately funded and supported to scale them to a point where they would have population-level impacts; and that any attempts to scale up need to be sensitive to the cultural differences of various communities.

Investing in children’s mental health services was also identified as an effective strategy for the prevention of problems and illnesses in youth and older adulthood.

As will be discussed further below, stakeholders also identified the need to integrate prevention, health promotion and early intervention services into community-based services, including primary care settings, so as to focus not only on the health of individuals, but on the health of entire communities.

Considering the public health role in the prevention of substance use and addiction, a reported disconnect was noted in the role of AFM and its reported priority on alcohol and other drugs, but to the exclusion of tobacco, whereas public health was focused more broadly to include tobacco and other addiction.

“From a public health perspective, we see all kinds of addictions, for example, eating, smoking, drugs and alcohol, but there’s also addictions around physical activity; ...and yet we’ve been fairly persistent with AFM about trying to get a dialogue around tobacco and have been told, ‘we don’t do tobacco’.”

6.2.2.2 Collaboration Across Multiple Stakeholders

In many ways, the themes that emerged under this broad heading of “Collaboration” intersect with those identified above for the Broad System Response and only those of particular importance will be briefly emphasized. Many themes and examples are also more fully developed in sections below that focus directly on access and coordination, particularly challenges and facilitators related to service coordination. This section stays a little more “high level”, leaving many specifics to this later section such as specific gaps in services, or challenges with transitions that could be addressed through improved collaboration. Lastly, it’s important to note that an exhaustive list is not provided of what was found to be significant examples of excellent collaboration among many stakeholders engaged in this process. However, some examples are highlighted that show what can be achieved with collaborative processes and which provide a foundation upon which to build.

Inter-sectionality of collaboration and the social determinants

There were many connections identified between the social determinants of health and the need for inter-sectoral collaboration and coordination. The majority of these are noted above

“Personal relationships as opposed to service delivery standards, tend to be the basis of positive and collaborative relationships....”

and need not be repeated here, but it is important to note that the nature and scope of these challenges, and their close connection to mental health and substance use/addiction challenges underpins a very strong argument for increased multi-sectoral collaboration. The need for adequate housing, basic

income, child care and transportation are but four examples that clearly call for the “*whole system response*”.

Building relationships and avoiding duplication

Several ideas emerged under the general theme of building collaboration through the cultivation of relationships. Relationships were frequently identified as critical to engaging and delivering effective mental health and substance use and addiction services and supports. On the one hand, personal relationships across organizations were often noted as the key to getting service for a client or family; more effective than the formal channels. The importance of relationship building was also strongly emphasized by community agencies serving newcomers and refugees, as well as Indigenous people. Many participants also emphasized the need for service providers to have the time and resources for relationship building in order to foster future collaboration.

The importance of relationships was also emphasized in the context of working in a small community which, while noted as a more difficult place to work in some respects (e.g., maintaining confidentiality), other factors were said to be so much easier, including fostering strong, sustainable relationships.

“Personal relationships as opposed to service - it highlights what we all know about working in Manitoba; it’s about relationships, relationships, relationships”.

Significant efforts were being made by several organizations to build relationships in support of collaboration and coordination, with one participant noting: “*we ...at least once a month, to bring another community agency to us; and that way we spend an hour or so and look at the collaboration that we have with that particular agency*”. One can also point to the networking and significant collaborative outcomes resulting from the Manitoba Addictions Agency Network as well as examples of good collaboration in system development between the AFM and WRHA (e.g., the second stage housing project at Main Street) and good partnership between AFM and PMH as well as CODI in the HSC. Also noteworthy is the collaborative partnership between The Pas mental health inpatient unit and Rosaire House. Another is the Bell Hotel- Main Street Project which is WRHA-funded and based on Portland Hotel Society model, with characteristics such as no eviction, damp housing, supports in place 24/7 such as community mental health workers, social work, etc. Excellent examples of shared care counsellors co-located with primary care, including My Health Teams, are also noteworthy, as were some collaborative initiatives with Child and Family Services (CFS) and Justice. Many of these and others are highlighted below in different sections.

These, and many other examples of collaboration, notwithstanding, many providers such as CFS, New Directions, Justice and AFM have reportedly developed, or are in the process of developing, SUA/MH services in response to the gaps in access and service coordination identified for the people they serve. This was not identified as an ideal situation, however, and some spoke of the strain on resources of feeling pressured to do so (“*We don’t need to replicate those things, we need access to them*”). Stakeholders highlighted that collaborative partnerships should ideally account for the “*collective capacity*” to meet the diverse and inter-related needs of individuals and communities.

The extent of duplication in service was also noted, typically connected to the many cross-sectoral or organizational siloes. On the same theme, many stakeholders reflected on the fact that is if often the same client or family receiving the services of multiple organizations.

“Systems aren’t interconnected; this system only sees this portion...; if I am a kid in the system, I have my counsellor in school, I have my mental health counsellor, then my psychiatrist and family doctor, child guidance counsellor, then employment insurance; interfacing with all these different systems; and not coordinated.”

This need to avoid duplication was also often linked to the need for supportive governance structures and accountability processes, some noting that the integration of Employment and Income Assistance (EIA) and CFS under one government department (Department of Families) had reportedly helped to sort out policy barriers. A high value was also placed on co-location, particularly between different service sectors. Some stakeholders discussed the value and promise of the co-location factor embedded in youth community hubs, since so many services can be brought to bear, including those focused on prevention and health promotion.

The role of government in supporting networking and collaboration was also noted and valued, for example, the Mental Health and Addictions Branch coordinating support for the Manitoba Addictions Agencies Network as well as the Manitoba Mental Health Agencies Network, the Mental Health and Addictions Management Network, and the Perspectives Provincial Mental Health Advisory Network (Perspectives).

The importance of community “hubs”

There was a high degree of support for the co-location of resources within specific communities or neighbourhoods. This was mentioned not only in the context of the “youth hub” which is being implemented in many Canadian jurisdictions (and a version of this model currently in the NorWest Youth Hub in Winnipeg), but also as an appropriate community-based model for adults. This approach was also seen as a way of connecting treatment and support with prevention and health promotion in a holistic way.

“Put all the supports in one place, deal with mental health, addictions and a place for people to drop in when they need support”

or neighbourhoods. This was mentioned not only in the context of the “youth hub” which is being implemented in many Canadian jurisdictions (and a version of this model currently in the NorWest Youth Hub in Winnipeg), but also as an appropriate community-based model for adults. This approach

The following excerpts from the interview and site visit transcripts illustrate the potential impact of these *one-stop-shop* models:

- From the Marymount group interview concerning the NorWest Youth Hub:

“ it’s similar the to Headspace model in Australia that we developed because we knew that youth didn’t want to access services outside of region. AFM is there three days a week, there are lots of co-located services, and then a partnership network to increase access to services, including primary care, employment services, and mental health. There’s no government funding. Hubs have to be in the communities; kids won’t travel and there is a trust that is built...there is a sense when you build community of service, then people trust that and seek help more”.

“..... clinic programs, for example, counselling, family planning, medical, wellness and health promotion, touch people at different stages of dealing with mental health before there are issues”.

“regarding creating a concurrent disorder competent team ... had any funding from government... but we have been able to bring AFM, primary care, MATC, youth employment services and family violence together in a small team that’s open five days a week; any youth between 14 and 24 can walk in and see anyone of those services.”

- And another example referencing the important role of integrating a public health nurse on-site:

“...it creates a different mindset and education for front-line staff... if you are a complex client, you are never alone in our site; we’ve been in schools where schools weren’t mandated for public health; its possible to make it work...it’s about mindset, not

necessarily about more money...look at needs and be more creative and do things differently”.

Other good examples of this integrated clinic approach were identified, for example, at the Women’s Health Clinic. All of these examples, emphasized the need to go beyond thinking about “specialized” services, and using collaboration and partnering as a way of achieving the “whole system response”.

Build the services into the community

Related to this enthusiasm for the community hub model was the view, particularly strong among community-based agencies, community members and people and families with lived experience, that services should be better distributed at the community-level - closer, more familiar and more flexible in meeting the needs of the individuals and families living there. Some community-based stakeholders felt that communities actually had more capacity to address population needs before deinstitutionalization, especially for people with less severe problems.

Stakeholders went on to identify a range of perceived benefits of community-based service delivery including:

- Less burden on clients (e.g., minimize the need for transportation, children are close to their parents, closer to natural supports, can continue employment)
- Greater ability to respond to the unique needs of different communities (“*Big systems are archaic and haven’t been updated to meet the current needs of the community.*”)
- Greater potential to reach individuals with SUA/MH challenges, particularly for children and youth and refugees and other newcomers who are less likely to engage with more institutional-based services. Agencies such as the Women’s Health Clinic, Klinik, and the Aurora Family Therapy Centre were identified as examples of agencies that have been successful in engaging community members. “*One of the strengths of the Women’s Health Clinic is quick access to services, including when waiting for more*

“We’ve never had a thoughtful conversation around what services should be delivered through community organizations that are nimble, and what services need to be delivered through formal health services, and how do we locate that. And then how do we create a thoughtful, equitable approach to delivering those services; and support through infrastructure that allows us to track impact. We have never had that conversation.”

“The not-for-profit world is the closest to families, trust, relationships, walking with them. This needs to be considered when developing the new strategy and needs to be resourced better.”

specialized services". Some stakeholders also thought that the emerging My Health Teams held promise in expanding the reach of SUA/MH services.

- Increased capacity to intervene earlier, before emerging challenges require more specialized services. In this regard, it was noted that not only would this prevent undue distress and suffering for many people, but it would also decrease the demand on the specialized sector (and potentially other social services) and improve access; in short, it was considered a more efficient and cost-effective way to serve the needs of the whole population.
- These benefits notwithstanding, stakeholders cautioned that concerns related to confidentiality and the need for anonymity may be a challenge for individuals living in smaller communities, and that support would be needed to build more community-based capacity. This could include increased access to less "visible" options such as virtual (e.g., online, mobile) and telephone based services.
- In the same vein, others noted that greater enhancement of community-based services would also require, and perhaps facilitate, a reduction in stigma, and increase public awareness and normalization of mental health challenges, including addiction, as a health issue that requires services and supports.

"Community-based organizations are not included in the transition out of treatment. Often these are the organization that have relationships and trust with the families and could be seen as a support".

Community mobilization hubs

During more than one consultation, participants praised the value of community mobilization hubs, a model originating out of the justice sector in Saskatchewan that brings key community agencies together for discussion of complex cases. As with the one-stop-shop, collaborative efforts involved in the community mobilization hub model were also described as working beyond governance and jurisdiction.

Feedback about the Block by Block Initiative, perhaps due to its funding through the Department of Justice, spoke particularly highly of this model, since it holds promise to at least bring better communication across the multiple sectors working with the same families: *"housing, employment, income assistance, child welfare, the justice system not working together"; "there is the Prince Albert Model, we have modified it a fair bit; we have more of a consent model, and ... engagement of partners on a long term basis. It takes time to develop relationships with families"*.

Models were also developed or under development in at least two of the RHAs: Interlake Eastern, with a collaboration table for complex children and youth, and in PMH. In addition to a very active and well-supported network of community partners working with PMH on community mobilization, they are advancing the community mobilization model outside Brandon:

“...you will hear about community mobilization, we are starting one Swan River. They come together and quickly advance response to individuals and families...so there’s justice, school, health, addictions, any number of partners at the table. And they refer to the table individuals and families that are acutely at elevated risk. And within 48 hours there’s a response to those individuals”.

Access to detox services and adequate housing, including supportive housing for people that require that level of support, were cited as two of the most common challenges for the community mobilization hubs.

Need for improved connectivity between mental and health and substance use/addiction

“The mental health system can be quite siloed especially hospital based services; they tend not to look outside their four walls.”

The call for closer connectivity between the province’s mental health and substance use/addiction services was also a major theme across the consultation process. Before speaking to this call for closer connectivity, it is important to acknowledge another

consistent theme in feedback about each of these two quite distinct sectors, namely the many challenges with connectivity *within* their own continuum of treatment and support.

Examples will be noted more fully in a subsequent section of specific access and coordination issues within each continuum of service. A few examples to note here related to mental health include transitions from hospital to community, from ED/crisis response to actual treatment; forensic transitions between SMHC and the PsychHealth Centre PX3 forensic unit; and the major challenge with transitions from child to adult services for transitional youth. The limited current collaboration between the several illness-specific, publicly funded agencies was also acknowledged, although some do share location and thereby achieve some operational efficiencies.

“There was a time when there was more collaboration. We had a Mental Health Literacy Network.... we did a proposal, this was a while ago, we got funding and then there was a desire to work together but that dissipated. Part of it is coming back to just different priorities and people falling off”.

For substance use services, the provincial network was said to be functioning more as a system (*"the addictions network is pretty strong"*), and many stakeholders in that network expressed this view because it is largely a provincial network rather than organized primarily as a group of regional networks. However, several challenges were also acknowledged, including connectivity between ER and crisis or stabilization services and detox; getting medical clearance before detox, getting detoxed before treatment; lack of intensive outpatient/day and continuing care services; and lack of connections between ORT and psychosocial supports. Both sectors are funded by multiple players in the system - addiction only less so given the AFM provincial mandate. To a certain extent, both sectors show the same potential for improved collaboration across different MHSAL-funded orgs, Other provincial government department funded organizations, RHAs, and private addictions organizations.

There is a clear implication for the ensuing Strategic Plan that recommendations for improved connectivity between mental health and substance use/addiction services will not be a panacea for the wide range of provincial challenges with respect to access and coordination because of significant challenges remaining in each sector, and high expectations in the context of this review for improved connectivity.

Another theme that emerged was how similar the respective challenges of mental health and SUA were, including many closely related to access and coordination. This list includes, but is by no means limited to:

- Being under-resourced in relation to the nature and extent of needs (e.g., expressed as partial or complete gaps in the service continuum resulting in wait times), including significant regional variation in needs and dedicated resources
- Dealing with extremely high and increasingly complex rates of co-occurring disorders
- Challenges with respect to the social determinants of health, and perhaps most importantly, housing and transportation as particularly critical
- Calls for investments to build a stronger provincial system for children and youth with more dedicated resources, while at the same time dealing with significant under-utilization of selected youth-focused services (e.g., AFM's Compass program for residential treatment and Northern Health Region's (NHR) Hope North for youth crisis support and addictions stabilization)
- The strong voice for more resources to be devoted to prevention and health promotion, including suicide prevention and reduction in stigma and discrimination
- Sensitivity to the needs of newcomers, including refugees, and the need for involvement, community-based focus, and spiritual/cultural supports
- A strong voice for more peer support, proctors and recovery coaches
- A strong voice in favour of more support for families

- Although regionally and organizationally variable, overall strong support for culture-based approaches for Indigenous people and active engagement in system planning
- Limited access to mental health services for SUA and vice versa for access to SUA services for mental health (e.g., expressed as both wait times and rules of engagement)
- Limited flexibility in services offered, including the need for more harm reduction services
- Acknowledged “slippage” in the training and related policies that were developed during the provincial CODI initiative, while also acknowledging some important efforts at cross-training and mutual curriculum development still underway.
- Praise for the existing COD program based in PsychHealth, as well as concerns about limited capacity in relation to need
- Reported success of some integration and collaboration efforts (e.g., Rosaire House and the inpatient unit in The Pas; collaborations in the PMH region)
- Expressed challenges of key stakeholders regarding hours and location of services and the need for more outreach
- Some important joint planning efforts, such as current considerations for developing a specialized addiction service at SMHC
- Both sectors reporting significant costs of out-of-province and out-of-country treatment
- Limited access to psychiatrists and psychologists
- Limited access to primary health care services including the need for more nurse practitioners
- Inefficient and inappropriate use of ED services
- Strong support for evidence-based practices and increasing interpretation of evidence to include that gained from experience and historical cultural practices
- After assessment and screening processes are complete, considerable leeway is reportedly given to a therapist’s choice of intervention, with limited monitoring through supervision or other accountability mechanisms
- Challenges working with CFS, including, but not limited to children in care
- Challenges coordinating with Justice, especially post-discharge and support for forensics patients
- Similar solutions proposed to enhance collaboration, including community hubs and the community mobilization model and multi-functional community health centres, as well as increased education of service providers and the general public

Three inter-related sub-themes from the consultation provide insight into the challenges that have been faced, and which will in all likelihood continue, without dedicated system enhancement initiatives in the context of the new Strategy.

One sub-theme is the universally reported, chronic under-funding of each sector in relation to need and the tendency to not only “protect your boundaries” but also support what service each sector is felt to be funded for, and most competent at providing. “SMHC referred to AFM and the client was returned; they <AFM> weren’t as familiar with mental health and they thought we <SMHC> were better at addictions than they were with mental health.”

“Even our COD program <hospital program> doesn’t want to take any people on benzos. Psychiatry is completely disconnected from CODI. Where is psychiatry in all of this?”

Another stakeholder noted: “we continue to prescribe meds that we shouldn’t because we can’t get people the supports they need”. And another cited the frustration of limited options for referral to mental health services: “It’s the most frustrating piece of my work when I have to say to a client, ‘This is probably not the right facility for you because we can’t manage your need’. We have a contract psychiatrist in AFM—just this week we sent an email about a woman in the women’s facility and he said, ‘You shouldn’t have her here, she is too sick’. Staff were consulting him, trying to come up with plan. He just said, ‘She needs to be somewhere else’. WHERE? <emphasis added to reflect tone of participant>”.

“Addictions and mental health - two different governance systems; different accountabilities; different value systems regarding how you approach client care. As an analogy ... families do better when two parents really understand each other/get married”.

Perhaps more important than resources and related challenges accessing each other’s services, however, were the reported fundamentally different world views about etiology and effective treatments; views. These views were said to be engrained in each sector, but ever so slowly giving way. Putting it simply, stakeholders reflected on the relative emphasis on the bio-psycho-social and spiritual/cultural model of mental health and substance use/addiction and noted

that different emphases are placed on the components of the model and also *within* the workforce of each sector. This also translates into the reported differences in the make-up of the workforce:

“<In AFM> we see that staff have a variety of training and backgrounds, some professional; a lot of folks with lived experience. As a result, we don’t rely on a specific discipline in Manitoba, like nursing. So there’s a lot of value in the addictions system; there is value in having multi-disciplinary staff and people with lived experience, not just relying on professional education.”

Cross-training and co-location were said to help break down some of these deeply engrained perspectives within the workforce, including key leaders in mental health and substance use/addiction and in other sectors as well.

The variability *within* AFM, and the slow pace of transition to different treatment models, beside the traditional 12-step model, were also noted in feedback on the addiction treatment workforce in the province. This included “slippage” in such things as treatment being declined on the basis of certain medications being taken - something not acceptable under the tenets of treatment and recovery support for co-occurring disorders, but said to be based at least in part on capacity to support people with complex mental illnesses.

This issue of medication support for co-occurring disorders seemingly goes both ways:

“Medicine will not accept an addiction patient who has co-occurring <disorders> and vice versa; they don’t treat them as a whole patient”. Similarly, “we can’t get kids into addictions treatment because they have a mental health problem that requires medication; we have had kids accepted and sent away at the door.”

“They <AFM, Behavioural Health Foundation> will flat out just say no. We are going back to the olden days regarding ‘get off meds first’. We are not equipped to manage it. We had a ten-year initiative to address this and made some headway but we are slipping.”

At the same time, access to psychiatric support was seen by others as critical to dealing with severe mental illnesses, from the point of view of both AFM and the Manitoba Addictions Agencies Network. The following

excerpts from the consultation transcripts highlight the variability remaining within AFM.

“AFM: [they say] “we don’t treat addiction like mental illness”... [it’s a] “terrible terrible shame...you need to be able to provide support right now.”

“Not a smidgen of change in relationships <with AFM>...Could we do any kind of joint therapies outside of Eden? The answer was no. We asked a mental health clinician, could a psychiatrist ever come to an appointment with a patient with AFM and the answer was ‘No. Not now. Not ever’ in the Southern region.”

“For AFM, we do have a half a day a week psychiatrist that comes to River Point and Women’s Detox in Winnipeg. That’s been very helpful. In fact, our Director of River Point Centre notes that quite likely we are supporting folks with more complex mental health needs because of that.”

The Manitoba Addictions Agencies Network also expressed strong support for increased, but shared, use of psychiatric resources:

We’ve suggested before, that most of us would be happy to share psychiatrists and psychologists; that we had access to, and could send our clients to, for those high needs. We know it’s unrealistic that we each have our own psychiatrist, or even a nurse practitioner who can prescribe when necessary and monitor these meds.

Lastly, while stakeholder feedback reflected a common value being placed on collaboration, in particular community hubs and community mobilization, the key difference was governance. Stakeholders from addiction, especially connected to AFM, reflected a strong preference to “locate under one roof” rather than developing a “one-person model”, which was to mean a completely integrated workforce capable of handling both mental health and substance use/addiction (presumably staffed within the RHAs). This view was aimed, in part, at retaining the benefits of a provincial organization, while at the same time supporting more collaborative hub models working more closely with mental health, as well as with other sectors. The majority of stakeholders from mental health did not express a preference for the governance model, but clearly articulated a closer integration of clinical and support services. They also noted the challenges in delivering a uniform provincial model for mental health services that came with regionalization.

Aside from connectivity challenges, when working with an individual client and their family, concerns about collaboration were also expressed at more of a systems level, for example, for collaborative planning, performance measurement, information systems and research and evaluation. The disconnects within the substance use/addiction sector were noted with respect to planning around the opioid crisis: *“We have been working hard at collaboration in the context of the opioid issue - but man, it's been hard. For example, who leads it? Where does addiction sit? The treatment piece?”*

With respect to other planning, as well as supportive research activities, the addiction sector was noticeably absent from several critically important activities, including the intense discussion about enhancing peer support in the province, the recent environmental scan regarding coordination challenges for people with a dual diagnosis—that is mental illness and a developmental disorder—and, to a lesser but still important context, My Health Teams. Important work of the MCHP also excludes addiction/AFM because they are not included in provincial, linked data systems in part due to their own challenges with a provincial information system.

Need for collaboration with primary care

Many stakeholders commented on the need for better collaboration with primary care, in large part because of the extent of its involvement and mutual interest and readiness of that sector to work with mental health and addiction: *“We just can't meet the volume of need in primary care and emergency settings. And the demand is going up as stigma goes down”*. It was also suggested

“We don't even know where to start, so we go directly to what we know, which is make a referral to psychiatry. We all know that that is probably not the best option for the majority of cases and that often leads to significant waiting”.

that, because physicians are currently challenged by significant issues related to access to services (e.g., lack of awareness, limited eligibility criteria and long wait times), they are less inclined to actively identify mental health and substance use/addiction challenges where they feel there is little they can offer individuals for support: *“Still more work to be done regarding coordination between primary health care and mental health. We need to work better together as a team. At our site, we do. In the larger system we don't. Each one wants the other to take over and manage. There's a lot of fear and trepidation regarding how do we work with these people. We don't know where to send these people”*. Alternatively, it was noted that family physicians tend to simply refer to psychiatric services.

Many stakeholders spoke with enthusiasm about the provincial rollout of MyHTs, which was seen to offer a strong collaborative care network model, although, as noted above, several stakeholders also noted relative lack of an addiction focus to MyHTs.

“We need integration at the clinical level - e.g., services exist but we can't get clients in because of strict eligibility criteria. They are great services but they need to be better coordinated. We need to break down barriers to access between services. My Health Team is an excellent example of a move in the right direction regarding joint decision making. We need collaborative care models”.

Several stakeholders also offered good examples of shared care underway, including in the Southern region and the WRHA.

“We have our shared care program, which is the short-term service connected in each of our major clinics; mainly first step, anxiety and depression; faster access; great collaboration with docs and psychiatry. They get an assessment and six to seven sessions. The main focus is CBT. It's very, very well used. It's newer to us. We've been finding our way. We've come a long way, and it's been quite successful.”

“I know we haven't heard lots of good things, but I would love to say that our shared care model with mental health workers physically located in service is critical. The physicians have someone they can consult with. They can make a quick referral. They caught that client in the moment. Investing that time would prevent a relapse, an exacerbation. It's a really good model.”

As noted earlier, community-based hub models that include a strong primary care component were strongly supported, including the youth hub model. Better integration of primary care and mental health and substance use/addiction was also identified by some stakeholders in the context of community clinics or the community health centre model. *“We are different than*

other organizations because we encourage you to think about the roles of health centres which have often integrated physical and mental health teams. Often Access Centres do too. The more we can integrate services at the front end, the more successful we will be.”

Physicians also spoke about their need for support and clinical consultation, looking, for example, to the RACE program developed in British Columbia⁹³ and being implemented in the WRHA: *“RACE: led by WRHA, but other RHAs are welcome to use it. It has limited capacity and has no coordinator.”*

As noted above, in general, when people spoke of shared care with primary care, they tended to be speaking about mental health, and either assumed substance use/addiction was included or that a role for substance use/addiction had not been concretely defined. Within the mental health sector itself, those advocating for more peer support in the system expressed concern about being excluded from the development of shared care models, and also discussions around RACE.

“We were all supposed to be in there but that didn’t happen. Even though there is shared care, they don’t use the self-help agencies. So we’ve been shut out of that” model.”

“We are bursting at the seams at Mood Disorders all throughout the province and yet there is a disconnect. People are finding us, they are coming to us. We do have doctors recommending us. We have been reaching out to docs. We can’t fill the number of pamphlets that they want from us. But where the disconnect seems to be is at the primary care level.”

Another important theme that emerged around primary care and collaboration was with respect to ORT and the need for more primary care physicians to take on patients for maintenance after that have been stabilized in the specialty clinics. This was said to require more community physicians certified for prescription of suboxone and methadone. Family members who had lost loved ones to opioid overdose spoke strongly and very emotionally about the need for better physician training regarding opioid prescription, as well as the need for better oversight and monitoring of prescribing practices. The variability and risks associated with prescribing

“We have colleagues around who are very generous prescribers. I don’t know if they want to be liked, or that they never learned the language; that they don’t know how to say no”

⁹³ <http://www.raceconnect.ca/>

practices of some physicians was also noted in discussion with addiction medicine specialists involved in delivering ORT.

The provincial group working on primary care reform, including the rollout of MyHTs, discussed the potential for synergy with the present work on the Mental Health and Addictions Strategic Plan and provided a written summary of their feedback. Many points that were offered synchronized with the input from other stakeholders. Some of the consistent themes and highlights of the feedback from Primary Care include:

- Challenges with long wait times and poor coordination across “siloed SUA/MH systems” with the exception of extreme cases such as threats of self-harm; both access and coordination challenges were said to be a result of lack of funding, stigma and discrimination, both patient and self-imposed system barriers (e.g., Personal Health Information Act, PHIA), and a lack of awareness around available resources and scope of practices.
- Lack of providers trained in ORT and challenges with the over-prescription of opioids.
- Recruitment and retention issues in SUA/MH services in rural and remote locations.
- Suggested solutions included the need for more standardized processes to streamline information flow and access to services (e.g., care pathways, information sharing tools and technology such as eReferral), and navigation supports for patients with complex needs.
- The lack of data on the overall demand for services (e.g., from AFM) and a need for standards, better governance and relationships between the RHAs, and service provider and jurisdictional challenges with coordinating care between Indigenous communities and non-Indigenous service providers.

The top three recommended priorities when looking across both access and coordination issues included:

- Developing a more upstream approach to mental health and substance use screening and treatment to support health promotion, prevention, early interventions and health recovery. Considerable emphasis was placed on enhanced screening and brief intervention, building upon past work in the province through the Drug Treatment Funding Program (DTFP). This will require careful attention to rapid pathways to accessible care for those patients who will be identified but whom will require more than brief intervention.

- Community development and policy development to support the integration of SUA/MH resources within a MyHT context, as well as provide service coordination and outreach to people with vulnerable and complex needs. This would focus on both greater access to services for people with mild to moderate SUA/MH challenges through MyHTs and greater access to ORT.
- Establish common service standards and pathways related to mental health and substance use/addiction training, screening, brief interventions, referrals and improved resource utilization, in primary health care, including piloting within MyHT settings.

Aside from these recommended priorities, the feedback from primary care stakeholders emphasised the current positive state of readiness in the province, which was also a resonating theme throughout the consultations. It is clear too that “addictions” is clearly included in the vision for Manitoba’s primary health care reform, including MyHTs. This formal feedback also highlighted that service delivery models connected with collaborative care models such as MyHTs should be inclusive of peer support. An important cautionary note was added about the need for the Strategy to consider the impact of cannabis legalization on primary care practices, emphasizing in particular the need to prepare primary care to take on a role in evidence-based, medically-assisted treatment with cannabis, for example for pain management or anxiety. In this regard, it is important to also note that new cannabis-related screening and brief intervention materials will soon be available from Dr. David Brown who led the earlier DTFP work on screening and brief intervention for alcohol. This can significantly enhance the toolkit available for meeting the declared priority for earlier intervention for substance use and addiction. Lastly, the feedback included recommended performance indicators for monitoring collaboration between primary care, mental health and substance use and addiction service provision going forward. This is also an important reminder for the need for these and other indicators in the implementation of the broader Mental Health and Addictions Strategy itself.

“With over 300 primary care clinics in Manitoba... creating links to these existing resources represents an efficient way of expanding access to mental health and addictions services and improve health outcomes.”

Need for improved collaboration regarding children and families

A number of sub-themes arose with respect to the need for closer collaboration between mental health and substance use/addiction services and the programs and services offered through CFS.

“When CFS removes children, someone should be there to support the parent in the moment to provide treatment and support immediately.”

The most dominant theme with respect to CFS was the close intersection between processes around children in care and access to addiction and mental health recovery supports, including:

- Reported lack of coordination for mental health supports for parents and children. For example, the medical model was cited as a barrier to access: *“you can’t be admitted if there is no diagnosis, but you can’t access services to get a diagnosis”*. Considerable feedback centred on the need for “whole-family” treatment, not broken up with professionals trying to get the children services in one place (with great difficulty) and perhaps the parents in another.
- The impact when CFS removes children from their families, and the fact that families may then have their EIA supplements reduced. This was said to potentially result in their inability to maintain a two-bedroom home, which is a CFS condition to get their children back.
- Reported lack of awareness or appreciation of alternatives other than residential treatment for addiction, which was said to significantly impact both treatment costs and outcomes, as well as challenges for the family, such as cost and lost employment. This was also related to concerns when CFS mandates treatment to get the child back, and the addiction system maintaining that the required service is not appropriate due to the client’s readiness for change.
- Reported lack of understanding of relapse in addiction, that it is part of the journey, and that more flexibility is needed in considerations of children being removed or returned.
- Concerns that current processes do not encourage truthful disclosure of the nature and extent of substance use, and related difficulties, for fear of repercussions related to removal of children.
- Concerns about the challenges supporting people with substance use and addiction challenges since the province does not recognize or fund addiction as a disability (although it was noted that EIA can remove work expectations for individuals while they are in treatment so that they can maintain their housing).

“CFS has the right to say you need treatment before people get their kids back without an assessment – an assessment might determine residential treatment isn’t necessary”.

“Accessing addiction services includes identifying what substances people are using and historically has repercussions for being honest, such as having children removed from homes. This is a systemic issue that needs to be addressed going forward, to create a platform where people can be honest about what their struggles are and how we can be most helpful as service providers, based on their agenda, not our agenda, policies or procedures.”

With respect to CLDS and mental health material from a recent environmental scan submitted for this review highlighted the need for improved coordination and communication between CLDS and the Mental Health Programs offered through the RHAs. Stakeholders within or close to CLDS reported difficulty accessing mental health services for their clients with dual diagnosis and mental health service providers also reported being challenged to support these clients. Mental health service providers also reflected a concern that people with a diagnosed mental illness and autism, or other vulnerable populations, aren't eligible for services from either program (e.g., do not meet the IQ criteria for CLDS nor eligibility for long-term mental health services). Considerable regional variation in the coordination between CLDS and RHAs was noted. The consultant team noted the complete absence of substance use and addiction related issues in this environmental scan, despite an important research literature on its importance⁹⁴, although it was possibly assumed to be included under "Mental Health". That being said, the scan primarily involved the RHAs and CLDS and did not appear to have included AFM or other addiction providers.

Need for collaboration with justice

Several factors associated with the justice sector clearly connect to mental health and addiction.

Importantly, the sector is involved in the provision of addictions treatment at the Winding River correctional facility at Headingley and offers access to psychiatric services as part of the health care offered. In-house treatment was said to be impacted by a lack of Registered Psychiatric Nurses (RPN). Reflections were also offered regarding challenges related to access to psychiatry resulting from income differentials between those employed or contracted

"When incarcerated, the individual is no longer the responsibility of Manitoba Health. They have to go through the process all over again when released back into the community".

by corrections. Discharge planning to ensure continuity of care from correctional facilities was said to be severely challenged by several factors, including the inability to continue important medication if being connected to an addiction program, without access to psychiatry, as well as the wait times involved across the board. Overall, the lack of preparation for discharge was

⁹⁴ Chapman, S.L., & Wu, L. (2012). Substance abuse among individuals with intellectual disabilities. *Review of Developmental Disabilities*.33(4), 1147-1156.

decried, and major challenges related to medical supports and housing. Recidivism was said to be “the likely result”.

Other justice related issues and themes that came up in the consultations included:

- The important role being played by Block and Block (funded through Justice), including its mandate to improve community safety, its recent declared priority for substance and addiction, and the extent to which its work is grounded at the community level with excellent community, and increasing levels of service provider, participation in coordinated networks.
- The critical role being played by gang involvement in recruiting vulnerable youth and exacerbating mental health and substance use/addiction challenges through increased drug involvement, drug trafficking and sex trafficking. The prevention of gang violence was recommended as an important part of the emergent Strategy, including capacity building across multiple sectors and service providers, and attention to root causes in the social determinants of health.
- The important role played by the mental health and drug courts, and the expressed need for expansion.
- Significant coordination challenges exist between forensic services at SMHC and the WRHA, including different operating processes and risk assessment, and limitations in capacity of the PX3 forensic unit and the WRHA’s community-based Forensic Mental Health Program. This at times results in patients waiting for extended periods of time in SMHC or PX3 because they are unable to be discharged due to inability to find appropriate housing with supports that meet the Criminal Code Review Board conditions. This inability to discharge patients to the community also means that inmates with mental illness who require a psychiatric inpatient admission sometimes wait for extended periods in a correctional institution because they are unable to access a mental health bed.
- Due to lack of capacity of WRHA’s Forensic Mental Health Program (FMHP) and gaps in services for offenders with mental health issues, there are offenders who are being released from correctional institutions after completing their sentences, such as sex offenders, who are at risk of re-offending. With added capacity, the FMHP could

“The <Gang Action Agency> Network was sending out requests to do consultations with ministries – we would get the same response: “That’s a justice issue...”. There’s a lot of misunderstanding regarding gangs and where they should fall under. Justice is the band-aid. Once we can engage in the idea of a prevention component, a lot more departments are open to having conversations and trying to understand. Schools need to be involved because they are the next safety net (e.g., intervening with bullying, providing a safe space).”

provide clinical support services to these individuals, which would minimize their risk of harm to others and of re-entering the justice system.

Collaboration with school-based services

School based services were identified as an important context to provide children and adolescents with the skills they need to cope with life's stressors, including as part of school curricula. The availability of supports for mental health and substance use/addiction in schools was said to vary across and within regions. As with services in the specialized system, mental health and substance use supports were said to be delivered separately and with little to no coordination with respect to avoiding duplication of services/coverage, including, in the case of mental health promotion and illness prevention, with the public health sector.

"In a lot of communities there is a divide between education and health; separation means that child and youth not accessing official services especially in rural and northern regions."

While the presence of AFM in some Manitoba schools was reported by some stakeholders as a strength, others suggested it as having "slipped". There were also concerns that it was dependent on each school's ability to fund it; a reportedly "*awkward model*". In terms of mental health services, while a few stakeholders felt that schools have done a "*decent job*" of providing mental health literacy programming to teachers and students, stakeholders were more likely to identify mental health promotion and illness prevention as a gap. The lack of coordination across the many contracted self-help/illness-focused organizations was also noted.

"When starting to bring in refugee families, the impact of those people coming was one thing, <but also> impacts on school systems, teachers, classrooms are another. Some of the kids haven't been to school in three years – there are gaps in learning, trauma; a huge push on mental health that isn't addressed."

Finally, as some stakeholders cautioned, services offered to students (either within or outside of school) need to be safe, accessible and effective ("*AFM may be in schools to tell people about options for help but they don't mention the long wait times*"). Concerns with trust were frequently noted in the context of youth and school-based services ("*Youth would use services in schools if they could trust them and met their needs*"). Youth and service providers alike described how some youth are hesitant to disclose their concerns out of fear of repercussions (e.g., being forced into treatment or removed from their families; "*Youth want a discrete,*

gentle approach, not a bunch of strangers getting involved”). The connection to youth and the need for trust also was noted by refugee families.

Stakeholders reflected on the need for collaboration between post-secondary schools and local services, given the high needs among student bodies (e.g., high rates of anxiety and first onset of other mental illnesses, as well as binge drinking and related incidences of sexual assaults). As well, student enrollment and retention were reported as increasing priorities for universities and colleges, with more efforts being devoted to recruit “non-traditional” students (e.g., students from low socioeconomic backgrounds, students from minority cultures, students with physical limitations). This was thought to impact future service requirements that could partly be met through collaborative work with community providers. Comments were also offered about the “business case” for this collaboration, to the extent that it facilitates training, education and employability of students.

Jurisdictional challenges

Many jurisdictional issues were identified that were said to limit the ability to provide programming to Indigenous people living on reserve. The challenges working with (and around) jurisdictional issues were well-expressed by one participant who noted: *“I’m responsible for a large federal reserve—Rosseau River; so there’s a significant amount of work about trying to figure out who provides services to this person; all these jurisdictional issues; then I can’t do that and I can’t provide this paperwork; so ultimately, we just red tape ourselves in all kinds of circumstances. We can’t seem to figure out how to get systems to cooperate; to broaden to see how each case should actually be put together”.*

“the jurisdictional attitudes of organizations and services that need to follow their own policies which often do not include collaborative efforts, although mental health and substance use are often linked”.

Many participants also saw the consultation process for the Strategy, and the eventual Strategy itself, as an opportunity to work together and break through historical federal and provincial jurisdictional issues. New funding opportunities, such as under Jordan’s Principle, were also seen as important in this regard.

While most frequently identified in the context of federal and provincial jurisdictional challenges in the provision of services to the province's Indigenous population, jurisdictional concerns were often quite broader, reflecting the number of organizational siloes.

Jurisdictional issues were also said to be affecting access to services for newcomers, for example, after they obtain Canadian citizenship, the families involved in the consultations noted that they were then excluded from newcomer-related services that they may still require.

Building collaboration and partnerships was cited as the optimal way to bridge jurisdictional issues. Several stakeholders also endorsed the importance of just being daring at times and to *"ignore"* jurisdictional issues.

"School systems are disconnected from mental health systems, which are disconnected from other mental health systems, which are disconnected from other mental health systems. Nobody seems to want to work with multiple systems to work with these kids to get them while they are young; prevent things from happening before they get older".

6.2.2.3 System Supports

Leadership and Governance

Stakeholders frequently identified leadership and governance as potential solutions to a range of issues related to access and coordination. The need was frequently cited for the **integration of substance use/addiction and mental health services** under one governance structure, noting that *"Manitoba is probably the only province that keeps mental health and addictions separated into silos"*. As noted earlier, this view was not shared by AFM, who continue to see significant advantages of a provincial entity, and see *"increased collaboration and coordination"* as the way forward rather than complete administrative *"integration"*.

"Mental health and addictions has to be 'stuck together' or else nothing will change."

Many reflected on the optimal governance structure to ensure closer clinical integration of mental health and addiction services. Comments also reflected the observation that addiction and, to some extent, the mental health system was also functioning outside of the broader health system and better linkage was also needed in that regard. Notably, the feedback from primary care stakeholders included the recommendation that priority to be given to establishing governance and policy that would facilitate close engagement of mental health and substance use/addiction in major initiatives such as MyHTs.

Others took this one step further and called for more centralization of BOTH mental health and substance use/addiction, stating for example, *“regionalization has created problems in my humble opinion, barriers... we need to be under Shared Health”* or *“I truly believe that mental health services need to be centralized provincially”*. This view sometimes prompted questions and discussion about the new SH organization and its suitability and capacity to manage and guide a system that requires so many different community and “non-health” partners and perspectives to be meaningfully engaged. Others were even cautious, noting that system-level integration is helpful but not sufficient for service-level integration and coordination (*“We will end up with stovepipes under one administration”*).

Comments that reflected other perceived challenges with governance and leadership included:

- The reported tendency for RHAs to put boundaries around their services in response to high demands and limited resources (so-called “perimeter-itis”) – *“Before we regionalized, we probably had a better network for child and adolescent services”*.
- SMHC being a government run facility meant it has fallen under a hiring delay for quite some time, as well as expenditure management, resulting in an estimated 50 unfilled positions on top of 50% of vacant psychiatry positions, resulting in a reduction in service, including lack of access to technically “open” beds.
- The need for provincial standards and guidelines that are attached to accountability mechanisms (*“government dollars are flowing to programs with no evidence base for them”*).
- Challenges with coordination between MHSAL and the RHAs, for example, coordination of funded agencies to ensure coverage and to avoid duplication.
- Inconsistencies across RHAs (*“All the regions are doing something different”*)
- The need for leaders who can drive significant change (*“I still see the same leaders and nothing has changed over the years”*)
- The need for governance with clear lines of accountability
- Challenges in scaling up, spreading, and sustaining innovations - the CODI initiative being the most commonly cited example of a strong initiative that lost significant momentum and impact due, in part, to the loss of the provincial CODI coordinator, which was a temporary position and not renewed.

Stakeholders also discussed the importance of meaningful engagement of a range of stakeholders at all stages of change, from high level planning to implementation and evaluation. This was flagged in relation to:

- The reported lack of engagement of stakeholders from other sectors (e.g. Public Health) and from within community-based agencies for past strategic planning efforts, and when significant changes are introduced to the system.

- The need to involve Indigenous leaders and organizations to establish trust in dealing with jurisdictional and other issues and ensure respect for cultural-based approaches to healing.
- The need to involve refugee and other newcomer stakeholders to ensure that their unique and often nuanced needs are sufficiently understood (*“They need to feel they are partners and owners in the system; without that there will always be a sense of being separate from”*).
- The need to include people with lived experience and family members in planning, implementation and evaluation of the overall system and major initiatives.

Questions were also raised about the level of leadership being shown with the scope of change within *“clinical consolidation”* and the lack of consultation. Stakeholders noted the apparent low priority for mental health reflected in this process. *“.. low priority for mental health was reflected – we < mental health > are 3%, so just a small piece – more managers are unprotected by unions, therefore we have given up much more than other areas - closer to 40%”*.

“Everyone is working with the best of intentions and making efficiencies – there is just a point where we need to say ‘Stop’, and give us the resources we need to deal with this demand for service”.

A number of stakeholders also reflected on the amount of change happening in the system and, for the most part, saw this as a sign that the *“time is right”* for a mental health and substance use/addiction strategy that will result in significant and positive system-level changes. That being said, others commented on the amount of change underway at the present time, for example, clinical consolidation in the WRHA, including the significant managerial budget cuts, and the process underway *vis a vis* the creation and role definition of SH.

Funding

Several themes emerged with respect to funding; the strongest theme being that **past and current funding has not been sufficient to meet the need and demand for services**. This view was sometimes nuanced around acute mental health services getting more funding in the past than community services and also that children’s services were seen as particularly disadvantaged in terms of funding relative to adult services. Across the board the view was advanced that arguments for increased funding could and should be made on the basis of the disproportionate funding compared to need, and inter-provincial

“.. we know from primary care and emergency that mental health is their most difficult, most complex <issue to address>. They don’t know what to do and there isn’t enough of us to meet those needs <they> are facing. And it’s not that we don’t have the solutions and that we don’t have ways that meet the needs. We just can’t meet the volume”.

comparators, as well as the solid research on the likely return on investment. Some other specific funding challenges that were cited included the increased costs for contracts for community residential mental health services, and the fact that mental health gets “no volume increments” as compared to, for example, home care. For many key stakeholders, funding and funding cuts did not appear to be following any plan or apparent rationale: “Find \$23 million; cuts are being made to core services in the RHAs while being added by MHSAL, and others”. Along these same lines, funding was also seen as increasingly influenced by advocacy of key stakeholders, again with no provincial plan.

“... what is getting funded these days? Primary care is funding positions, Manitoba Health is funding positions, but we have got our plans and they don’t get funded. So, we end up with resources in areas that we would never have said are a priority. So there’s a mis-match”

As noted above, the chronically low-level funding and ongoing funding cuts were seen as reflecting the low priority for mental health and substance use/addiction in the province relative to other parts of the health budget. Working with the same or even less resources, while at the same time providing treatment and recovery support to people dealing with increasingly higher severity and complexity of needs, was said to only strain the situation further. That, and important work on collaboration and aiming to meet the needs of people with less serious challenges, were seen as the primary factors underlying increased wait times, expressed as “bleeding our core services”.

A related theme was the view that provincial funding was not allocated **proportionately to need and context across the regions, or actual service delivery patterns**. An example given was the trend for many people discharged from SMHC to move to Winnipeg for longer-term community supports, resulting in a disproportionate need for resources in that part of the service continuum. This is summarized above with respect to the need for population-based planning.

Another point made by several stakeholders was the strong argument for more funding based on the “**cost of doing nothing**”, with participants citing the cost of Medevac from the north, and also sending physicians and other health professionals from Winnipeg to northern or other remote communities. The cost of out-of-province and out-of-country treatment was cited as another example.

Another theme connected to funding was the very **limited opportunities for capital spending on infrastructure**. Referring to St. Boniface Hospital’s McEwan Building which does not meet

Accreditation Canada standards for a mental health inpatient unit *“Infrastructure is kind of important—buildings, equipment, everything, basics... some of our buildings are falling down. Accreditation Canada said we should blow <it> up and rebuild. It stays at the bottom of the list. Mental health doesn’t hit the radar”.*

Another commonly expressed theme concerned the challenges experienced **scaling up projects after successful evaluation or pilot projects**. The province was also seen as always being in *“demonstration”* or *“pilot testing”* mode, and then being in the position of needing to ask for money to scale up successful projects and then waiting (and waiting). Examples included, but by no means were limited to, successful demonstrations of home-based mental health care teams, Program for Assertive Community Training (PACT), peer support and Healthy Child Manitoba’s Insight program. Another is the Emergency Department Violence Intervention Program (EDVIP) which has not be renewed or scaled up despite a successful evaluation. Also frequently voiced was the lack of funding and missed opportunities for prevention, health promotion, and early identification.

Lastly, the timing of this Strategy in relation to funding national opportunities through Jordan’s Principle, as well as Federal commitments announced for mental health and addiction, was seen as creating excellent opportunity for thoughtful and much needed investment.

Research and knowledge exchange/translation

Many participants throughout the consultation spoke highly of the research being conducted in the province, which has informed program and policy development and evaluation. Frequent positive mentions were made of the work of HCMO, the MHCP, and several individuals and departments of the University of Manitoba, and Health Sciences Centre (HSC). These conversations often prompted the sharing of documents, fact sheets or other data used in the earlier sections of this report.

Research exchange and translation involves, in part, the application of research evidence into practice, and several important examples were identified. Particularly noteworthy was the work of the Knowledge Exchange Centre of AFM, such as their review of evidence on options for ORT and the subsequent expansion of support for this medication by government. The way in which the Centre engages its stakeholders in consultation regarding evidence, and its application in the Manitoba context were highly regarded. An excellent example of research translation was evident in the tour of the Crisis Response Centre (CRC), in its adoption and on-site evaluation of group intake and group treatment for a range of common mental illnesses and problems.

A theme did, however, emerge among stakeholders about the need for more population level surveillance data to inform system planning, for example, drug use in the general populations, including youth, and in post-secondary institutions.

In addition, a need was expressed for more “*pockets of innovation*” as well as more focus on how to spread and scale-up successful interventions. The need for more focus on implementation science was commonly cited in this regard and connects to the theme identified above with respect to the lack of funding support beyond often very successful demonstration projects.

While several stakeholders challenged the lack of scale-up, as well as the strength of evidence underlying some services being offered in the system, there were examples of fairly rapid implementation of evidence-informed practice, for example, implementation of the “Good Samaritan Act” to save more lives in the midst of the opiate crisis. This Act provides safety from potential prosecution and anonymity to people who report a possible overdose situation.

“And my direct service provider staff—my heart goes out to them. They are passionate and they care and they want to change the world and they work long hours and do a whole bunch of stuff off the side of their desks. And they are burning out. We are not investing in them. We are letting them sink”.

Diverse and competent workforce

The most common theme, by far, with respect to the workplace was the view that the workforce itself was the greatest asset of the mental health and substance use/addiction system(s), often working under challenging conditions and with limited resources. This support for the workforce was also couched in terms of a concern for both the sheer scope of change underway and possibly on the horizon (e.g., overall impact of major system reviews such as that done by KPMG, the Peachey report, and the present Strategy development process; clinical consolidation and other budget cuts; the looming and largely unknown impact of SH), as well as the overwhelming workload. This theme connects to many other sub-themes related to the workforce, including:

- Limited or no regular pay increases in most organizations to match cost-of-living
- Elimination of staff education and training in budget lines, including out-of-region opportunities
- Limited time and resources for clinical supervision
- Pay inequities in the system

- Unfilled positions due to expenditure management, stress leaves or other related factors

As with an earlier section on collaboration, there were several important strengths in workforce development, including some continued training and cross-training regarding co-occurring disorders and on-line cultural competency training. An interesting and helpful connection was also made between increased work satisfaction and the team approach that was ensconced within collaborative, shared care models, including community hubs. Our aim here, however, is to focus on areas for potential system enhancement, especially those that impact access and coordination of services.

In terms of challenges, one of the most significant was in the areas of recruitment and retention, also connected to all the points above, and said to be particularly challenging in more rural and remote regions. A significant number of positions were noted as unfilled for a considerable length of time, a factor said to influence both access (e.g., wait times) and coordination (e.g., helping clients transition). The hiring freeze at SMHC was said to lead directly to closure of “open” beds due to long-term unfilled positions. Another challenge noted for communities in the NRHA, as well as many other of the province’s rural and remote communities, was the level of training and experience of local workers and how best to utilize outside consultation, for example, telephone, online, telehealth, in these situations.

Stakeholders often brought up the issue raised in the Peachey report concerning the *per capita* imbalance in Manitoba’s complement of clinical psychologists compared to other Canadian jurisdictions. Mixed opinions were raised about this, for example, some being very supportive and noting both value for money from psychologists compared to adding more psychiatrists, and the possibilities to ramp up graduation quotas if funding was available. The “UK model” was cited as a good example of the integral role of PhD-level psychologists and a team approach, including support from Master’s level psychology graduates. Others expressed concern about the extent of the therapeutic role of clinical health psychologists in many current contexts, and also the relative need in relation to other professional groups (e.g. psychiatric nursing). Aside from these points made with respect to psychology, others noted that no regulation or standard is in place for who can provide counselling in Manitoba, thus making workforce planning and defining core competencies a challenge.

“...the lack of provincial database to ‘compare apples to apples’. We are currently using an ‘antiquated’ system <MHMIS>, and collecting unnecessary information and not providing anything useful. We would very much like the system that SMHC has. The data can make a business case for the restructuring of existing resources and the need for additional resources <InterRAI database>. It would also provide standardized tools for clinicians <e.g., outcome measures>.”

Several stakeholders decried the reduced level and scope of training for nurses in addiction and mental health, and a corresponding reduction in formal placement opportunities. Consultations undertaken by AFM for the purposes of the Strategy development process identified that: *“AFM’s diverse set of educational backgrounds among staff created inconsistencies in quality of service, particularly for counselling. Internal trainings such as motivational interviewing and introductory addictions courses are not enough to fill the gap. Participants reported a need for more qualified clinical staff and support.”* In a previous section on the connectivity between mental health and substance use/addiction, we commented on stakeholder feedback within AFM concerning the level of competency to provide treatment and recovery support to people with complex mental health challenges. Here we would add their concerns that many had not taken the basic CODI training modules due to staff turnover. As well, the feedback from staff with more recent CODI training was that the modules *“were outdated and too basic”*.

The issue of peer support was also highly salient as a workforce issue, given stakeholders awareness of the support for the model in the research literature, an acknowledgement of the past history with peer support in Manitoba (generally viewed positively), and the current influence of strong advocates for peer support in the system. A related workforce issue was the extremely high level of support shown for proctors working in many mental health services and their role in providing practical supports for clients. Many, but not all proctors, were said to have lived experience with mental health challenges - it is not a prerequisite to being a proctor. Furthermore, the emergence of formally trained *“recovery coaches”* in the Manitoba addiction system was viewed as a positive development. Taken together, these developments support the diversification of the SUA/MH workforce, while at the same time same calling for guidelines and policies to support effective integration. Along these lines advice offered during consultation with those advocating for more peer support for mental health services was for peer support workers to be employed outside the formal organizations, such as the RHAs.

A related workforce issue raised by several stakeholders was the need for a provincial health human resources strategy to identify provincial roles and responsibilities for clinicians (and peer support workers). There was also a sense that cultural competency with respect to working with Indigenous people should be enhanced. Several stakeholders (Indigenous and non-Indigenous) also articulated a need to support more Indigenous people to enter mental health and substance use/addiction related professions.

Information Management Technology

Challenges related to multiple, often antiquated, information systems across services and sectors,

“We are having to reinvent the wheel because clinical information does not travel with clients”.

many of them still paper-based, was identified as a significant barrier to:

- Facilitating efficient transitions between services and minimizing the need for clients and families to share, and often repeat, difficult information about themselves.
- Implementing common mechanisms to support service delivery (e.g., embedded screening and assessment tools and continuous outcome measures).
- Collection of system-level data that would inform provincial, regional, and service level planning, performance measurement, evaluation and knowledge exchange.

Stakeholders discussed the importance of a provincial strategy to successfully and broadly implement a shared provincial database and to resolve the current “patchwork system”. Examples include the complete separation of the addiction information system as well as the lack of connectivity of hospital and community mental health information systems. Informed stakeholders noted that a strategy would also need to address the important conflicts between the Mental Health Act and the PHIA, which has reportedly been a barrier to electronically sharing information across health services.

“the primary care doctor, the psychiatrist, don’t have access to good electronic medical records that cut across systems. It’s a very expensive but fundamental problem... Hospitals have one system, primary care another, community a third... and AFM. Mental health went on the same one that home care has been on for years, and then Selkirk has another one still, so even within mental health we don’t have one system.”

It is important to distinguish the consultation

“See the 2014/2015 Deloitte technology and info management and analytics review. Both said the same thing: pockets across the province; the need to focus on the whole as being greater than sum of parts. Five reviews <Info and Analytics study, Information Communications Technology; ER review; Peachey; KPMG> all talk about the siloed approach, no planning and alignment across orgs, sub-optimal performance, and design flaws in the system. It has been said for five years but government has not galvanized, but it’s hard to ignore five studies”.

feedback concerning information systems that move client information across providers for treatment and support purposes (e.g., Electronic Medical Records or EMR) and information systems that support performance measurement and accountability (although the former is often used for performance measurement purposes). There was a high degree of support for improved EMR among stakeholders across multiple sectors, including primary care, the RHAs and also AFM, although challenges in building this system were noted by all sectors given the current siloed nature of the overall system and potential impediments through PHIA.

Building more comparable systems for performance measurement was also highly supported, both at the organizational-level (e.g.,

for equitable caseload management, outcomes) and at the system-level (e.g., system metrics for population health planning; evaluation of major initiatives such as MyHTs). Here the multiple, independent systems being used within and across organizations were said to present huge challenges, including the lack of connectivity of addiction information. These challenges may well become more salient given the current Federal initiative to develop a common set performance metrics for mental health and substance use and addiction services, and potential for buy-in to these metrics as a condition of Federal enhancements to mental health and substance use/addiction funding.

Stakeholder considerations about future performance metrics included a concern that they must adequately take into account the complexity of need and the amount of staff time needed to provide adequate treatment and support.

There was also feedback that the data currently available on service utilization be used to its full extent.

Lastly, with respect to monitoring of post-treatment health outcomes, an oft-neglected aspect of performance measurement, the work in this area of AFM and the Behavioural Health Foundation deserves laudable mention.

“Nobody is looking at our mental health drug utilization patterns and trends to see if it aligns with what needs are in the community.”

6.2.2.4 Indigenous People

One of the strongest themes that emerged throughout the consultation process was the high proportion of people with Indigenous background engaged with virtually every stakeholder group delivering direct service. Stakeholders viewed this as a reflection of the high needs of Indigenous people, needs that were multi-dimensional in nature and grounded in complex historical roots of colonization, residential schools and other trauma, as well as current socio-economic and environmental challenges. **“Healing”** was the one word used to express the hopes and aspiration for the anticipated Strategy, as well as the belief that the Indigenous community itself has the strength and resilience to **“heal from within”**, that is, calling upon historical strengths and resilience in their own culture. The Strategy was viewed as a potential facilitator of that process.

Another strong, and closely related theme, was the importance of linking the Strategy, as well as the process of its development, to the larger process underway with respect to both the Truth and Reconciliation Commission, and particularly concerning Calls to Action Regarding Health - #18 to #24. The relationship between the Strategy and the consultation process was also drawn to the National Inquiry into Missing and Murdered Indigenous Women and Girls. Multiple connections to the Inquiry were made including, the same roots in colonization and

historical trauma, the fact that a significant number of women had the experience of sexual abuse as well as being children in care, following a correlated trajectory of moving away from home, lacking attachment, shortened education, being homeless, and being vulnerable to

“We are all on the same river but paddling in different boats”.

victimization, and ensuing stress and fear experienced by the entire family. Stakeholders also drew attention to the First Nations Mental Wellness Continuum Framework as a guide to understanding mental wellness as a key component of health, if not serving as a model for a strength-based approach to addressing mental health and substance use/addiction challenges.

As aspirational as these themes are, stakeholders were very guarded in their expectations of the Strategy and the process in which they had been engaged. This was said to be based on past experience in similar processes as well as a “*déjà vu*” when providing data to government to justify the need for more resources, but typically receiving little, if anything, in return. This was summed up in one group meeting by the Anishinabek word “*mano*”, which literally translates “let it be” as in “don’t worry about it, nothing will change”. This well-known expression summed up for participants the **high level of caution that this review and the subsequent Strategy would bring much needed mental health and substance use and addiction services to their communities.**

These expressed concerns aside, several themes emerged that articulated several specific needs, as well as hope for system enhancements. Needs identified included:

- Significant challenges with respect to the inter-generational trauma of colonization and the residential schools experience, and the parallel lack of supports for trauma, including PTSD, in reserve communities.
- Common reports of extremely high opioid addiction in Indigenous communities, compounding problems with alcohol and other drugs, such as crystal meth and cocaine. Challenges were identified in accessing withdrawal management services, as well as ORT, due to a lack of such resources within a reasonable distance.
- The challenges with the high rates of suicide and the vicarious impacts on mental health, substance use and other health professionals in the community. The need for staff wellness was expressed, as well as for support from outside agencies during such times of crisis. This connected to a reported lack of overall crisis support for many communities.
- Challenges with housing, transportation and employment in the community that were said to be limiting motivation to refer people out of their community for treatment since

progress towards recovery was so difficult to maintain upon their return. More resources were said to be needed within the community itself.

- With respect to youth, stakeholders noted the lack of recreational opportunities and the ensuing level of boredom, which was said to be too easily alleviated by drugs and alcohol.
- The high rates of children in care which, while bringing people into treatment as a condition of getting their children back, may also challenge both help-seeking (e.g. loss of financial benefits) and recovery (e.g., externalized versus internalized motivation for healing).
- Highly variable access to provincial resources for Indigenous communities, with multiple reasons expressed for this fact, including variable policies and capacities of the external mental health services (e.g., RHA-based), transportation or child care issues, and lengthy, complicated and costly intake and admission procedures.
- Challenges related to lower wages for mental health, substance use and other health professionals working Indigenous communities and related challenges with recruitment and retention.
- Variable use/acceptance of culture-based approaches in provincial resources, although the consultation and site visits identified several examples of excellence, including Rosaire House, Marymount, Behavioural Health Foundation and, of course, the NNADAP-funded family program at Sagkeeng.
- Racism and discrimination, experienced at many levels, but most frequently expressed in terms of long and unsupportive waits in the province's emergency departments and other health services
- Communities struggling to maintain their cultural identities which, in turn, was said to challenge the involvement of elders in the treatment of community members, since they were losing a sense of their role and status in the community.

Despite all these challenges, stakeholders expressed hope that new resources coming on stream would begin to make a difference, including funding being made available through Jordan's Principle, community-based crisis intervention services, and MATC's new funding for expanded tele-health child and youth mental health services to 63 communities, to give a few examples. In the Sagkeeng community, a new proposal is under development for an extension of their family program and the development of a new withdrawal management facility. Lastly, a strong theme emerged concerning the resolve to use the Strategy as an opportunity to challenge and improve provincial and federal jurisdictional issues that limit the ability to provide services to First Nations people living on and off reserve.

Inuit people - While a small population in Manitoba, stakeholders expressed concern that Inuit people are particularly vulnerable and have significant unmet needs. Many Inuit people move south to Manitoba, typically from Nunavut, to access health services that are not available in the north. Many stay in Winnipeg and are faced with a range of issues including being away

from their culture, families and natural supports. Dedicated services were noted as lacking with comments offered regarding:

- The Inuit Centre, which provides housing for Inuit residents of Nunavut while on medical travel, having strict policies including no drinking/use of substances and no visits from family and friends. It also does not provide community resource supports.
- Other community based housing supports having a long history of providing supports for Inuit people are limited by difficulties getting funding, related in part to jurisdictional challenges.
- The Manitoba Inuit Association operating with very limited funding and staff resources.
- Vulnerability of young Inuit people, particularly young women and girls, to gang involvement, prostitution and sex trafficking.
- The lack of transition supports back to their home communities.

6.2.2.5 Age, Gender, Equity and Diversity Issues

The theme of health equity and diversity⁹⁵ with respect to planning, delivering and evaluating mental health and substance use/addiction services, came through strongly in these consultations. Stakeholders argued for a strong and consistent focus on disparities in the social determinants of health amongst different communities and regions, and amongst specific population groups. Many programs were said to be “*designed to meet the needs of middle class populations, not vulnerable populations*”. This also connected to concerns about the tendency for services to be centralized in Winnipeg, and the limited access to these services from residents living outside that area – typically referred to as “*perimeter-itis*”. Overall, stakeholders expressed the need to ensure that services are in place for populations inordinately impacted by health and social inequities. In short, there was resounding support for a strong health equity lens in all aspects of the Strategy related to system planning, resources, and assessing performance; again, retaining the focus on access and coordination of services.

⁹⁵ The majority of equity and diversity- related issues concerning Manitoba’s Indigenous people are reported separately above. However, many also resonate in this section as well.

Many system inequities were identified related to class and income, including better access to private services if income allows, cost of treatment, which can include required fee-for-service psychological diagnostic assessment—as it will be available more readily on that basis, costs of “damage deposits” to enter a residential program, costs of child care and transportation to and from treatment, as well as lost work time for mandated residential addiction treatment. These income related disparities are also “place-based” to a large extent, with population needs clustered in certain regions, and even neighbourhoods, and poor alignment with available resources.

“There is a lack of equity for people in the region. They have to go out of region for services; away from homes and natural supports. This is especially challenging for people who don’t drive; who don’t have phones.”

Newcomers and refugees: Stigma associated with SUA/MH challenges are also reportedly compounded by class disparities as well as racial and cultural discrimination. This theme was particularly salient among Indigenous stakeholders (as noted above), but also expressed by newcomers and refugee participants, including youth. Challenges raised by these participants included:

- Difficulty learning about the Canadian system and customs—exacerbated by challenges with the English language—which was reportedly very stressful and affected the ability to access services
- Cultural differences in parenting, and resulting fears that children will be taken away (*“CFS is ripping newcomer families apart – it’s very traumatizing for families who have already experienced a lot of trauma”*)
- Fear and distrust of government services based on country and/or culture of origin
- Experiences of racism and discrimination, including when seeking employment
- Experiences of racism and bullying among children and youth, and susceptibility to gang involvement which promises a sense of involvement
- Financial hardships:
 - Challenges finding employment due to language barriers
 - Pressure to pay back transportation loans provided by the federal government

Children and youth: As noted several times already, many participants highlighted the disparity in overall funding for children and youth services; this disparity itself representing an equity issue as well as a poor investment in prevention with an eye on savings down the road. Some inequities in services for children, adolescents and emerging adults were said to include:

- The perception that children and youth services are a low priority relative to adult services (“*we are the orphan of the orphan*”; “*adult services seem to overwhelm everything*”). One stakeholder also highlighted that this demographic is increasing along with the older adult population and that planning should reflect this.
- The critically important negative consequences for children placed in care, and the particular challenges accessing child and youth mental health services.
- Lack of child psychiatrists and psychologists, and considerable regional disparity.
- Emerging concerns regarding the impact of cannabis legalization in light of current poor access to services and the potential increased in need for treatment for cannabis-related problems.

“These children are often put into care to access resources but there are not the appropriate resources for them in care. They will go from shelter to shelter until CFS has exhausted what is available and then kids are returned to parents with no support.”

Children with complex needs were seen as particularly difficult to locate services for, including:

- The reported lack of services for children under the age of 12 with complex needs, including children with neurodevelopmental disorders such as FASD, Autism Spectrum Disorder including Asperger Syndrome.
- Lack of specialized services for some youth 14-17 years of age resulting in the need to send them out of province for costly treatment services
- Youth involvement in gangs (i.e., carrying weapons, selling drugs, being trafficked for sex; being severely at risk when they want to exit: “*it’s so sad; those kids are really on their own*”)
- Already well-known challenges providing services to transitional youth who age out of children’s services but still require services as emerging adults – they essentially start over

Another important equity issue is the significant under-utilization of two critically important youth resources in the province – AFM’s Compass program and the NRHA’s Hope North program. Clearly, there are youth who need these services but, for to-be-determined reasons, are not comfortable accessing.

Youth engaged in the consultation process expressed significant concerns about current models of treatment, noting in particular – “*lack of trust, especially in the school context*”; the treatment models as being “*out-of- date*”, the need for “*more emphasis on harm reduction; longer treatment, flexibility on cell phone use; and alternative therapeutic models such as art or music therapy*”. On more than one occasion in the consultation process, youth expressed their challenges with traditional “*counselling*”. Indigenous youth stated the need for a stronger

cultural component, including land-based healing, although excellent examples, such as at Marymound, were noted.

Older adults: Challenges related to support for older adults, included:

- The rapidly aging population in the community, and limitations in capacity for dementia care, depression and substance use/addiction, including managing suicide risk.
- The rapidly aging population in many service delivery contexts – referred to as “aging in place”, and with concomitant increases in service needs and costs. Examples of significant populations aging in place included in SMHC, PACT teams, residential care homes and other supported housing settings, and Winding River correctional facility.
- Limitations in the current capacity of personal care homes (PCH), especially related to supporting adults with a mental health diagnosis, including behavioural challenges.
- The extent of social isolation and the concomitant need for outreach capacity and collaboration across a range of community resources.
- Elder abuse

Gender: A wide range of issues and challenges were raised with respect to gender, many of which have been touched on in earlier sections. Here we note the importance of the following issues:

- A shortage of addiction services for women
- Variability in the priority of services for pregnant and parenting women – although given priority for ORT and other addiction treatment, a report was also given from a woman denied treatment because of being pregnant
- The impacts of post-partum depression and the need for access to services
- The impacts of partner violence –one participant made a plea to have domestic violence clearly included as part of a provincial collaborative model for mental health and substance use and addiction.
- The stress on mothers of children being placed in care and challenges accessing mandated services as a condition of return of the child or children because of related transportation costs and costs of time off work, both of which are particularly challenging for women given well-established income differentials.

Lesbian, Gay, Bisexual, Transgender, Questioning, Queer (LGBTQQ) community: the predominant issue faced by the LGBTQQ community was physical and emotional safety within treatment facilities (“*people don’t feel safe in the facility <referring to Main Street Project’s Detox>; they are judged, insulted, sexualized*”). Transgendered youth did comment positively on being able to access either men’s or women’s facilities and being able to switch if not comfortable. In a consultation and site visit with AFM, participants also noted their provincial

Diversity Committee as an important step forward, as was their participation in the annual Winnipeg Pride Parade.

Other people with very complex needs: A number of other important groups of people were identified as having a high level of need and less than equitable access to services. This included:

- People **with developmental disabilities (intellectual) and mental illness, including substance use and addiction** (i.e., dual diagnosis or concurrent disorders).
- Individuals with **physical limitations**; for example, when service buildings are not accessible for people who are differently abled (e.g., have mobility, sight, hearing challenges).
- Persons with **Acquired Brain Injury (ABI)** - while this population is served by the mental health system (e.g., Thompson and SMHC for ABI units) some stakeholders believe the system is offering insufficient services for their needs, since they often have co-occurring mental illness, including substance use and addiction, behavioural issues, physical limitations, and cognitive impairments.

6.2.2.6 The Continuum of Services and Evidence-Informed Interventions

Our approach here is to focus on the two broad themes of:

- Access, and
- Coordination

We are unable to reflect all the regional nuances to the information gathered, nor can we selectively focus on any one target population. We do, however, allow relevant variations to arise thematically. In each thematic area, we interject relevant issues for different parts of the services continuum and sub-populations that arose as sub-themes. To help maintain our focus, we repeat in the appropriate sections below the definitions of access and coordination that are guiding our system review and synthesis of findings.

6.2.2.7 Access to Services

Access to services is a complex concept and experts agree that several aspects are relevant. If services are available and in adequate supply, then the opportunity to obtain service exists, and a population may *'have access'* to services. However, access is also related to the *affordability, physical accessibility and acceptability* of services. Furthermore, services available must be relevant and effective if the population is to *'gain access to satisfactory health outcomes'*. The availability of services, and barriers to access, have to be considered in the context of the differing perspectives, health needs and material and cultural settings of diverse groups in society.

The definition of access to services, as well as the nature of the consultation feedback, suggests that a distinction should be made between situations where the service or service capacity is essentially non-existent, versus situations where the service is theoretically available but is just not accessible for a variety of reasons. We also comment on the rare, but important, situations identified where services were available but that were reported to be at very low occupancy for significant periods of time.

1. Service capacity just not available

Facilitating access but limited capacity to respond

Some stakeholders noted that increased efforts to reach and engage individuals with mental health and substance use/addiction challenges is important and necessary but that there needs to be services to which these individuals can be connected.

"The problem is that there are waiting lists everywhere in the system, so access centres just add more people to be seen unless there are more resources".

- Deinstitutionalization of individuals with severe mental illness was said to have not been well planned, and the impacts are still reflected in communities' lack of capacity to meet their needs. Lack of services available to treat major mental illness was also identified (*"individuals become ostracized"*)
- The large number of access lines into mental health services across the province, which can further challenge access to services if nothing is available to meet the need
- Feedback on the CRC in Winnipeg and limited options for disposition

Lack of community resources to facilitate step up or down transitions

- “Perimeter-itis” – limited access to, and flow-through of, clients in psychiatric beds, including beds at SMHC; high number of persons in Alternate Level of Care (ALC) status awaiting discharge due to lack of options for community transition
- Lack of access to “step-up” specialty programs, such as eating disorders and DBT, for treatment of people with personality disorders. The limited number of medical treatment beds for eating disorders was linked to the high number of out-of-province treatment referrals and associated cost
- Lack of detox/WMS and stabilization services throughout most of the province to stabilize and prepare individuals for addiction treatment.
- Shortage of community-based mental health services, including and assertive community treatment models (PACT teams)
- Shortage of forensic mental health beds
- Limited capacity in Personal Care Homes (PCHs) to respond to complex clients with mental illness and behavioural challenges (e.g., older adults with dementia, individuals with neurodevelopmental issues). It was also noted that while smaller, more home-like settings are better for supporting quality of life, they are also more challenging to resource.
- Early Psychosis Prevention and Intervention Services (EPPIS) were reportedly limited to the WRHA and PMH. Stakeholders from PMH shared that efforts to deliver Early Intervention Services (EIS) via telehealth was met with limited uptake, in part because of a lack of local capacity to provide crisis supports, and that the successful delivery of EIS requires “local coordination”

“they end up making referrals to programs, but <also> handing out the number for the crisis team because they know something will happen while they are waiting”

Significant gaps in services continuum

- Stakeholders commonly identified the lack of withdrawal management services (WMS) as a gap in the continuum of services, particularly medical detox. This was said to be particularly acute in the North⁹⁶ and other rural and remote areas, given challenges related to transportation and the need (and often lack of) transition supports back to home communities. Some stakeholders discussed the need to explore other options to deliver WMS, including mobile, telehealth and other community-based services.
- The availability of specialized housing with supports was the most frequently identified gap in the mental health service continuum because they simply do not exist or they are not available to individuals with complex needs. Specific gaps identified included:

⁹⁶ Concerns were raised, however, about potential under-utilization of the WMS in Thompson and which will be further assessed in the next phase of the project

- Transitional housing
 - Supportive housing
 - Housing that accommodates individuals with physical limitations
- Opioid replacement therapy was identified as being in very short supply, although with somewhat better access due to the recent addition of Suboxone to the provincial formulary; but still no ORT in rural and northern regions, except for Brandon. This was largely attributed to a shortage of prescribing physicians. Extremely long waits were also identified for AFM’s ORT clinics in Winnipeg and Brandon.
- Availability of mobile crisis is reportedly region-specific with inequitable access even in times of severe crisis.
- Lack of services for families and caregivers, including respite support, family-centred counselling and supports, family-oriented residential treatment, and supports related to having informed consent to participate in loved one’s treatment and recovery support plans.
- Lack of clinical counselling and therapeutic supports, for example, to address intergenerational family issues, trauma, grief and loss, and stress related to the burden of caregiving. The need for increased clinical skills was identified within AFM.
- Health promotion, prevention and practical supports (e.g., transportation, home visits, parenting support, child care). A shortage of proctors was identified in community mental health services.
- Lack of Peer support, throughout the system, but particularly in EDs, crisis settings, such as the CRC, and to assist with hospital discharge. More variety in community peer support groups was also identified as a gap, as well as more recovery coaches for addiction support.

“When you get a bad reference from Manitoba Housing, nobody else is renting to you.”

“Taking individuals out of the family setting and not supporting the family as a whole is a barrier.”

2. Service is “available” but not accessible

Stakeholders reinforced that reaching out for help is often very difficult, highlighting the need for low barrier, timely, accessible and welcoming services (“that first call is hard to make”). The following areas were identified as significant concerns:

- All stakeholder groups identified a lack of awareness of, and difficulties with, service navigation, as significant barriers to accessing services. The point of entry into services was frequently described as “confusing”, particularly for families, but even for service providers (“it’s difficult for service providers; imagine for somebody homeless”; “how do

we help people get to the right door that feels very supported and seamless?"). Other areas of concern include:

- Limited awareness among service providers due, in part, to high turnover of service providers in the mental health and substance use and addiction system
- Concerns regarding the clarity and accuracy of the AFM website
- Tendency to refer to more costly and limited psychiatric and residential services when less intensive (and costly) services are more appropriate
- Many concerns were expressed about the services not being “welcoming”. In some situations, stakeholders felt stigma was the real barrier: *“there’s lots of reasons presented why we can’t help you, as opposed to ‘thank you for coming. Let’s see what we can do’”*.
- Mental health crisis/urgent care or an ED is potentially available but there are no security services at the facility or no secure spaces for supporting clients who are at risk of harm to self or others.
- Restrictive “rules of engagement” emerged as a very common theme across almost all stakeholder groups, who reported the tendency for service agencies to adopt rigid and exclusionary criteria that leaves a large percentage of people with no access, particularly those with complex needs. This was sometimes couched in terms of limited resources and needing to focus on agencies’ identified target population (*“It feels like some programs/services pick and choose who they help”*).

Specific examples of these rules of engagement include:

- Onerous referral and intake processes (e.g., lengthy application packages, cost, security deposit; the need for medical clearance, which is only available off-site (*“clients are lost in that movement”*))
- Medical Addictions Unit for WMS at the HSC is largely limited to severe alcohol cases
- Requirements that clients voluntarily present to services, which was seen as particularly problematic for youth (*“It is ridiculous to expect a youth to voluntarily say yes to treatment for meth. We are guardians and caretakers for these children”*)
- Requirements for a period of abstinence to access substance use/addiction services (*“Kids need access to services while they are using. They can’t wait to be sober or clean... they will be back on the treadmill”*)
- Excluding clients from mental health services on the basis of the need for “trauma-related services” to address behavioural issues. This was cited in the context of accessing mental health services for children in care.

- Lack of mental health treatment and recovery support in substance use/addiction services.
- Ineligibility of children with intellectual disabilities for EPPIS
- Age cut offs between youth and adult services, presenting major challenges for transition youth.

“It’s administratively easier to have that <age> division, but it doesn’t serve the population at all. It actually mis-serves them. They end up dangling. Literally.”

These rules of engagement were particularly relevant for individuals with complex needs (e.g., co-occurring mental health and addiction challenges, challenging behaviours related to neurodevelopmental conditions, children and youth with significant behavioural and psychosocial problems, including children in care). Several stakeholders remarked that these rules of engagement are probably not a reflection of a lack of desire to help, but rather reflects the limited resources and high demands for services, and the resulting need to “protect” the services for those individuals for whom agencies feel they are best equipped to support.

- The long wait times for many services was explicitly mentioned, including for residential addiction treatment, ORT, access to psychiatry and for any community counselling.

The need for immediate connections to services, including drop-in options, was felt to be particularly important for youth (*“When youth go somewhere for help, being told they will get a call or an email is not effective. They need the support in the moment.”*) It was not

“people get sicker because resources aren’t available when first reaching out for help”

uncommon for stakeholders to contrast long wait times for mental health and substance use and addiction services with services provided for urgent and serious physical health conditions (e.g., cardiac, cancer). Stakeholders also identified the need for

supports while individuals are waiting for services (e.g., online self-management, peer supports).

- Limited hours of service availability were also often cited, for example, AFM (*“they don’t do after hours”*). While there were clear examples of AFM doing outreach (e.g., in schools, probation offices, community centres), there were still some stakeholders who identified AFM outreach as limited, particularly in rural communities (*“they don’t do home visits”*); this was seen as especially problematic for older adults who are already at risk of isolation. Similar comments were offered for mental health services operated by the RHAs.

- The intake and admission hours for inpatient beds at SMHC were said to be significantly impacting the ability of psychiatrists and others in the IERHA to respond

to clients in urgent need of admission, despite the fact that IERHA has “designated” acute beds at SMHC.

- The need for more outreach was commonly identified by stakeholders. Concerns related to stigma were frequently identified as barriers to individuals accessing more “mainstream” services, particularly for youth. Outreach was seen as particularly important for vulnerable, high-risk, and isolated individuals. Outreach was said to be complicated by geographic expanse and travel times on often unsafe roads (*“we need to balance between doing outreach <driving hours> and being available in office. We have a mobile crisis team that does the most active outreach but travel time up is to two hours one way”.*)
- The impact of unfilled positions was noted in an earlier section on workplace system supports, but should be re-emphasized here because of the major impact on service accessibility due to lengthy staff shortages. While there were challenges reported filling certain positions through most of the system (e.g., psychiatric nurses), delays in hiring were noted as particularly challenging in rural and remote areas, including the North region. In the most extreme case that was noted, there were 50 unfilled positions in SMHC due to a government freeze resulting in no access to beds that were theoretically “open” for a significant amount of time.
- In some instances, the consultant team encountered services with very low occupancy for significant periods of time, important observations that will be followed up in the next phase through quantitative analysis. For the present, we highlight our observations of low occupancy at AFM’s Compass facility and NHR’s Hope North in Thompson. Consultation feedback also highlight potential occupancy challenges at AFM’s WMS in Thompson and, at times, Marymound’s Youth Addictions Stabilization Unit (YASU) in Winnipeg.

3. Factors facilitating better access to services

The consultations also identified many factors underlying access, and ideas for improvements, many of which are a counter-point to some of the challenges to access identified above. Some of the more important ideas are noted below.

Not surprisingly, expanding the supply and reducing the regional variability in service along the continuum was the most frequently mentioned suggestion for improving access – for example, expanding PACT teams and similar assertive community treatment models for rural areas and Indigenous communities; increasing services for children with complex needs; expanding options for WMS and ORT; and providing more residential addiction treatment services for

women. Investing in early intervention and prevention was also seen as an effective strategy with longer-term payoff, since it would eventually reduce demand and increase access for those who still require treatment and recovery support. Going beyond an increase in supply of services, and a significant investment in prevention and early intervention, many other helpful suggestions emerged.

Providing transportation support was one of the most frequently mentioned strategies for improving access to services. Examples were cited in other areas of health care, that seemed to stakeholders to reflect the stigma and relative low priority given to mental health and substance use and addiction. Improving access to housing, and when needed, housing supports, was also seen as a way to improve access to mental health and substance use and addiction treatment and other recovery supports, since they help stabilize the person's life, increase the chances of both help-seeking, and decrease missed appointments and other operational inefficiencies in the system.

Stigma in the community with respect to mental health and substance use and addiction was frequently noted as gradually diminishing, with the end result that more people were accessing services. The first point of access was said to be the primary care practitioner and the ED, lending some urgency to improved screening, interventions and well-developed care pathways from these settings into appropriate services. This can include placing dedicated mental health and substance use/addiction resources in the ED, or just ensuring supports are available when needed, such as in PMH where mental health workers visit the ED to support clients in crisis (*"we are community based but we will go and respond there because there are no other resources to do that"*).

While there are many access and intake points to the current system, some felt more *centralized access* models would offer potential solutions to at least some of the access challenges. This came with the caveat that, behind the access point, there must be a capacity to respond. Also noted was the need for well-trained and knowledgeable staff at the client-interface (*"we need to have people answering the phones who know the system; who are skilled at assessment and who can offer a client-centred approach with warmth and provision of choice"*). Specific mention was made of the need for more centralized supports to the Manitoba Inuit Association to help Inuit individuals connect to services.

Community hub models were consistently cited as an important community-based strategy for increasing access, including a critical walk-in component, as in the youth hub model. Similar positive reflections were offered for community health clinics, as well as community mobilization hubs. In general, there was strong support for locating treatment and recovery

support services closer into the community to facilitate access, for example, the Women's Health Clinic and its eating disorders program.

Expanding the hours of operation to include services offered in the evenings and weekends and walk-in options was recommended, as well as more localized locations such as satellite offices. The mental health services offered through the IERHA were seen as good examples in this regard.

Delivering more group-based services was also seen as a way of improving access, for example, the group psychoeducation classes provided through the Winnipeg CRC.

For youth, increasing access to service was mostly about faster access and longer-term treatment, but also about changing the current models of service and increasing flexibility (e.g., more harm reduction orientation, allowing use of cell phones to keep in contact with friends and family, and more varied and interesting approaches to treatment, including a stronger cultural component for Indigenous youth).

The importance of partnerships was mentioned through much of the consultation process, with PMH emerging as a region particularly strong in this area. Leaders from that region described how partnerships have contributed to significant community-based services available in this region, including for individuals with complex needs. This was reportedly related, in part, to the devolvement of the Brandon Mental Health Centre, and to ensuing, concerted efforts to develop and grow collaborative working relationships across the various community mental health teams and in partnership with community service providers. This was said to have resulted in the flow of complex clients into the region from other parts of the province.

The move within the province towards shared care with primary care, including learning from, and expanding upon, existing work in Southern Health and the WRHA but also lending widespread support to the MyHT approach and its provincial implementation. Support was also offered for RACE, while recognizing it was still in its beginning stages. Improving capacity for screening and brief intervention in the context of primary care was seen as an effective strategy for increasing access to services for people with mild to moderate mental health problems and those at-risk for alcohol or drug use issues.

Another common theme that emerged that was seen to hold promise for increased access was expanded use of telehealth, with the extensive experience in PMH and the Northern region as examples. The most common caveats that also emerged with respect to telehealth, however, were the infrastructure requirements and also the availability and experience of the workforce

in remote areas of the province that would benefit significantly from this technology. In addition, some people in the Indigenous consultations felt that telehealth was limited from the point of view of building a relationship and trust in the therapeutic process.

Lastly, the increased use of the Internet and mobile technology was suggested as a way to significantly increase access to services. While cautions were expressed about challenges with knowing the quality and effectiveness of different applications, such resources were cited as being potentially helpful in extending the reach of the overall system of treatment and recovery support. Lack of flexibility in major parts of the system in the use of texting was cited as both a barrier to access, as well as an opportunity for improvement. This was sometimes expressed as another reason to support smaller, community-based service providers as they were significantly more flexible in this regard.

6.2.2.8 Coordination of Services

Coordination of services can be considered at two inter-related levels. One can consider coordination of individual or family treatment and recovery support (e.g., the work of a service coordinator) as well as coordination of the overall network or system of service providers (e.g., the work of an inter-agency planning committee). A definition that is appropriate for both levels refers to the process by which multiple services and recovery supports, often provided by multiple sectors and service providers, are synchronized to address the needs and strengths of each person and family seeking assistance.

Challenges to Coordination

The fact that mental health and addictions services are administratively separate was said to challenge collaboration and coordination, although there were have been examples of their working together effectively.

“Services are “siloes” making it difficult to navigate and access, as well as plan.”

The provincial nature of the substance use and addiction system was said to facilitate coordination within that sector. In contrast, the regional nature of most of the mental health system presents challenges for planning and policy, as well continuity of care, when a hospital discharge occurs in one region but the person must return to their home community for mental

health supports. Even changing neighborhoods in Winnipeg was said to result in challenges with continuity of mental health services

The multiple funding bodies and differing mandates of major players in the mental health, and to a lesser extent, substance use and addiction services make it difficult to share patient information and also to develop common policies, standards, and informatics for planning. Sharing of information, sometimes in the context of PHIA, was cited as a significant barrier, although people also reported having become perhaps overly cautious in this regard.

“it’s very difficult to find partners, especially nowadays because they all want to see some significant compensation for getting involved with RHA”.

The multiple ministries of government that are closely involved in mental health and substance use and addiction, including Families, Justice and Education, requires a high level of communication, trust and collaboration. Stakeholders identified significant challenges with CFS in particular. Other examples of important administrative disconnects that reportedly need to be navigated include the fact that “Housing” sits outside of “Health” and yet is an essential component of the mental health and substance use and addiction system of core services. The same can no doubt be said for “Transportation”. Another example offered was that “Forensics” is funded by “Health” but depends on critical relationships with “Justice”.

There were common concerns regarding the capacity of EDs to identify and address mental health and substance use issues and then connect people to appropriate service. These included:

- Concerns that children and youth are not being connected to needed services (*“there’s a good percentage of kids we don’t even see”*)
- Lack of dedicated mental health and substance/addiction support services in EDs
- Challenges and time-consuming work accessing services from the ED

“There were seven phone calls made on behalf of one physician covering the entire corner of southwest <to find services>”

Stakeholders frequently identified that clients are often “lost” in the space between referrals and transitions to different kinds and levels of services.

Particular areas of concern include:

- The treatment continuum within substance use and addiction, for example, from detox to stabilization to treatment; from treatment to continuing care; from ORT to counselling and psychosocial supports
- The treatment continuum within mental health, for example, from a hospital facility (e.g., SMHC, Eden) to community (housing or to long-term care (PCHs, special needs

units) or from PACT to more appropriate services (“*they can’t get people off their caseloads*”)

- Difficulty accessing mental health and substance use/addiction services concurrently or sequentially, when needed
- Difficulties transitioning from correctional facilities to community mental health, substance use/addiction services as well as accessing basic health care services
- Challenges for families involved with CFS to access mental health and substance use/addiction services, for children or parent(s) and/or the family as a whole
- Difficulties for transition-aged youth making the change-over to adult services

Factors facilitating coordination

Building and sustaining personal relationships was seen as an important aspect of service coordination, although some stakeholders cautioned that this should not be the primary approach, given, for example, the loss of that connectivity when a service provider retires or changes positions. The value of good communication and relationship building was illustrated by mental health and substance use/addiction liaison with Indigenous communities in many parts of the province, and particularly in the NRHA, IERHA and PMH.

Many suggestions offered for increasing access were also seen as important for improvements to coordination, for example:

- Co-location of services in community hubs, with the NorWest youth hub being cited as an excellent example.
- Implementing formal navigator programs such as the Macdonald Youth Services Family Navigator Program was frequently mentioned. Peer support Workers or Recovery Coaches were also seen as particularly helpful in this navigator role.
- Location of mental health and substance use/addiction workers in EDs or MyHTs, that is, through shared care and practice networks.
- Locating mental health and substance use/addiction supports inside housing units such as Eden’s Housing and Support Services
- Centralized access for geriatric mental health services in the WRHA.
- Centralized intake such as MATC’s centralized child and adolescent mental health intake system and Youth Addictions Centralized Intake (YACI), facilitated by the co-location of mental health and substance use professionals and well-developed pathways to treatment and support.
- The AFM addiction help-line, and particularly the incorporation of a formal screening tool to support connections to the most appropriate service. Similarly, the AFM residential service integrated their intake process with community-based services, resulting in diversion of more clients to community based programming when appropriate.

Summary of the qualitative feedback from stakeholders

Although it is challenging to distill all the above qualitative information down to an informative set of highlights, the following is a list of key themes with a view to a subsequent synthesis of with the findings from the other main components of the project.

- High enthusiasm, engagement and expectations (“*this felt different!*”)
- Complexity of need at the individual and community level
- Need and demand have significantly outstripped capacity to respond
- Significantly variability in services available – a strength for some Manitobans (e.g. access to crisis services or ORT) is a significant challenge to access for others
- The workforce remains the heart and soul of the system, in spite of many challenges. Significant concerns with job stress, safety, recruitment and retention.
- Children and youth are at risk – significant resources and coordination are needed for prevention, early intervention and treatment
- Need for a multi-dimensional response that covers the full range of bio-psycho-social-spiritual-cultural approaches; more flexibility needed in treatment and support options
- Need for better governance model or models, most notably too many siloes and independent planning and accountability
- The need for improved integration between mental health and substance use and addiction
- The need for a multi-sectoral “whole system/multi-sectoral response”
- High Indigenous-related needs and cautious, but critically needed support is based on hope and resilience
- Access and coordination challenges are significant and at multiple levels – public and provider concerns are significant
- Strong role advocated for community-based services, including peer support
- Information systems and performance measurement are critically weak
- Better scale up, implementation and follow through needed on effective demonstration projects. More focus on the evidence-base of treatment approaches
- Better follow through also needed on strategic plans and priorities; more attention to change management and performance metrics

Specific gaps in service or coordination challenges frequently highlighted by stakeholders included:

- Withdrawal management, medical and non-medical, including community-based and mobile options
- More treatment options including less (exclusive) reliance on the 12-step approach
- Longer term residential addictions treatment as well as more pre and post treatment services, including post-detox stabilization

- Increased ORT capacity with psychosocial supports
- Wait times in general too long for both mental health and SUA services
- Supports needed for the public as well as service providers to increase awareness of what is available and how to access services
- Navigation supports for those entering and trying to transition across services and sectors, including transition supports from correctional services to community-based services.
- Forensic beds needed
- Housing supports in the community including an emphasis on facilitating better transitions (flow) from acute or chronic care services to free up inpatient bed space
- Transportation supports critically needed
- Insufficient integrated support for COD/high complexity and trauma, neuro-developmental
- More timely access needed to crisis supports and mental health assessment; less regional variability where significant gaps exist
- Enhanced SUA/MH supports needed directly in EDs
- Coordination issues with CFS, addiction treatment and RHA children’s mental health services
- Challenges with transitioning youth to adult service
- More well-defined support for harm reduction; improved/more coordinated provincial harm reduction services

6.2.3 Validation events and suggested priority directions

As described at the beginning of the report, validation events were held with a range of stakeholders, including service providers, system leaders, Indigenous communities, and people with lived experience and family members. These events were designed to share the preliminary themes that had emerged from the consultations and to provide an opportunity for validation of what we had heard and synthesized. We also participated in a “Primary Care Day” during which we significantly expanded our input from that sector by shared the findings to date and opening the floor for questions and discussion. Across all stakeholder validation events, the resounding message was that the themes resonated and reflected their experiences of the mental health, substance use and addiction system in Manitoba, including its connectivity with the broader health and social system. A range of data indicators were also shown highlighting the level of individual and community need and the resource gap in addressing the needs. This information too, resonated with participants experiences.

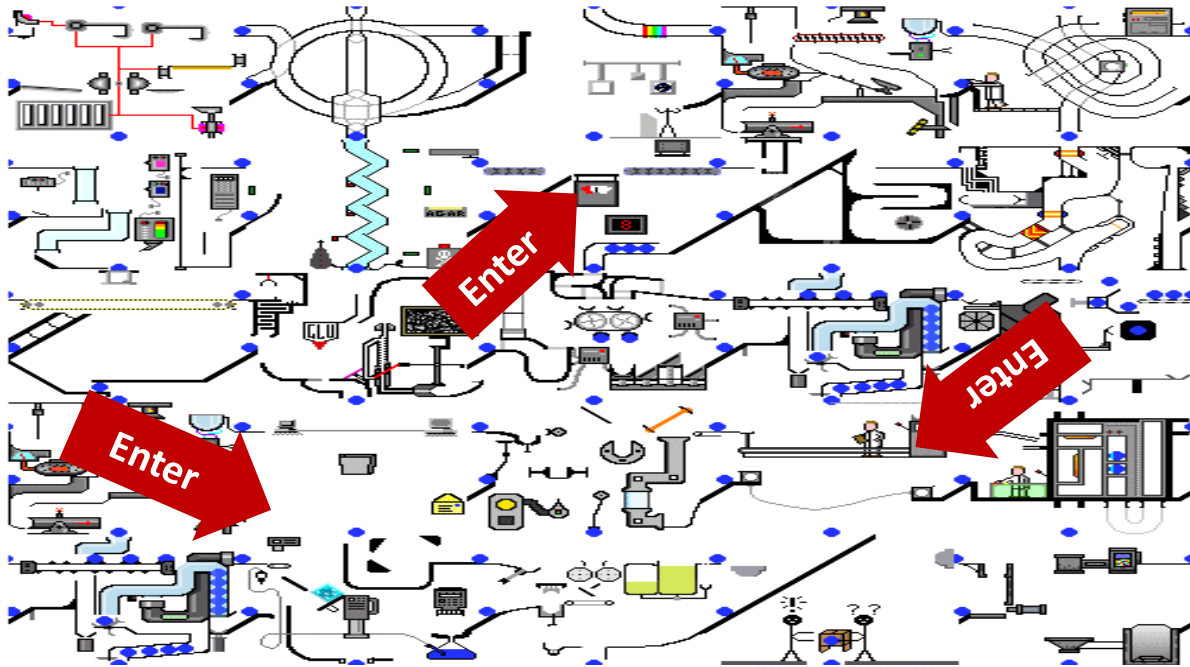
In a small number of instances, stakeholders identified additional issues that they felt either needed more emphasis (e.g., the need to ensure that youth are engaged in the strategic planning process; more focus on the older adult population;) or that was felt to be missing (e.g., the more input from newcomers and refugees, especially youth). Subsequent activities of the

consultant team worked to fill these gaps and the results have been incorporated into this report.

During the validation events a graphic image of a “pin-ball game” was used to convey a vivid summary of the current state regarding access to and coordination of mental health and substance use and addiction services in the province – multiple entry points and challenges with navigation. The analogy was also useful in conveying the message that, as in a real pin-ball game, adding money to the game results in longer play time but not necessarily the best result. This set the stage for subsequent discussion of strategies for system enhancement that would, for example, build on collaborative relationships, while presenting the best business case possible for increased resources where needed to bolster the system. This graphic figure is shown below and resonated so well with participants that it has become a bit of an iconic image for the main findings to date.

The second objective of these events was to get a sense of the priorities for strategic planning, from the perspective of the different stakeholder groups. Working with the broad principles of the review for example, “Population Health Approach”, “Importance of Collaboration” “Indigenous Populations (see [Section 5.0](#)), stakeholders were asked to identify their top three priorities with respect to access and coordination. The main categories were broken down into sub-categories and a bit of an evolving process emerged over the course of the groups. For example, following the first validation (with Child and Youth service providers), an additional category, “Individual and Family Interventions’, was added at the request of participants. In each event participants placed three “stickie notes” on poster boards organized according to the key principles and sub-categories. A clustering and actual count of notes gave a sense of relative priority over the full range of options for system enhancement, while keeping a focus on issues related to access and coordination. We grouped the results across the various events and found most support emerging for the two broad categories of “Total Systems Response” as reflected under a broad population health approach, and “indigenous Populations”. Within the specific topic of “improving access” priorities emerged for ‘Individual and Family Interventions’ and ‘Prevention and Health Promotion’. In terms of coordination, priorities emerged for working to improve “Transitions in Care’ as priorities, again with a “Total Systems Approach’.

Figure 18. Graphic image of the pinball game illustrating challenges with access to and coordination of services



6.3. Quantitative performance indicators and assessment of current coverage

6.3.1 Wait Times and other Operating Statistics

Table 6 below provides a suite of operating statistics for Manitoba's residential SUA services. Of particular interest are the wait times for service, in part because of the significant concerns expressed related to access to services during consultations and validation events, as well as from both the general public and service providers in the on-line survey.

For stabilization and withdrawal management services (WMS), the wait time is typically immediate, although there are usually forms and processes to be completed for intake and assessment, for example, completion of the medical clearance form for Main Street Project's WMS services. Also, residential treatment services such as the AFM Eaglewood program in Thompson provide initial WMS and some of the beds used for this purpose may be accessed by

community members not going on into the treatment phase.⁹⁷ In Table 6 the wait time (and occupancy data) are reported for both program phases together.

With respect to residential treatment and longer term supportive recovery programs (i.e., aftercare), wait time can also depend on other program-related factors, including whether there may be an additional wait for intake and assessment, and also whether the program operates on an open or closed intake cycle. In addition, as noted in the table below, entry into one of the supported recovery programs is often time-dependent on release from an earlier facility, for example, a correctional facility or one of the AFM programs. With these caveats and variations in mind, the following observations arise from the wait time data in Table 6.

- The wait times for residential treatment are lengthy between the point of seeking treatment and entering treatment, and confirms the general impression arising from the consultations and on-line survey.
- Wait times are significantly longer for women as compared to men.
- Wait times are longer for AFM-operated programs compared to relatively similar non-AFM programs, such as BHF, Rosaire House, and Tamarack Recovery Centre; that is to say, generally similar in terms of treatment and recovery goals.
- Access is relatively fast for youth seeking services from the AFM Compass program, although during the consultation process, feedback was provided that time-intensive intake and assessment processes are required prior to admission.

Occupancy rates, like wait times, can be affected by several programmatic factors, such as open or closed cycling of programs⁹⁸, as well as factors related to seasonal variability, for example due to hunting season or Christmas holidays. That being said, there are several examples where occupancy is less than 50%, in particular, the AFM youth program (Compass – 27%). and the youth stabilization unit operated by Marymount (YASU – 22% to 41%, for voluntary and involuntary beds, respectively). Interestingly, the Main St. Project men’s and women’s withdrawal management programs ranged on average between 56-66% occupancy for 2016-17. With respect to residential treatment, most of the programs reported occupancy over 80%, although there are some in the 60-75% range (e.g., the AFM Men’s program in Winnipeg (58%) and their Women’s program at River Point Centre at 74%).

The information in Table 6 refers to residential services only. With respect to the province’s substance use/addiction community-based services, the vast majority of which are provided by AFM, the wait times varied significantly by individual program and geographic location, including satellite offices. In general, for adults, wait times ranged from 4-5 weeks (e.g., adult

⁹⁷ More recently the WMS service is viewed as the entry phase to the residential treatment program. Prior to this the beds were more open to community members for withdrawal management without necessarily going on at that time to treatment.

⁹⁸ Some residential programs offer a structured 3-4 week program and everyone must start at the same time. In this situation people who leave the program early can not start immediately. They must wait until the next program cycle. This may leave beds unoccupied for a short period of time

group), up to 10-11 weeks (women's group). Adult post-treatment services were lower and often immediately available. For youth, the wait times were much lower, although the range was broad – the NorWest Co-op Youth Hub had a zero-wait compared to the Youth Starfish Program at about 15 weeks. Resource Assistance for Youth reported no wait time for their services.

Table 6. Wait time and other Operating Characteristics for Manitoba's Residential/ Inpatient Substance Use/Addiction Services, 2016/17.

Type of Service	Population Served	# of beds	Wait time (days)	% Occupancy	LOS (days)
Stabilization					
YASU Involuntary	Youth, M/F	4	-	41.5	5.7
YASU Voluntary	Youth, M/F	4	-	22.5	4.8
YASU IPDA	Youth, M/F	2	-	6.5	7.5
Withdrawal Management					
HSC Medical WMS	M/F	11	-	90-100	¹
Main St. Proj –Men (Martha Street)	M	25	-	66	6.8
Main St. Proj - Women (River Point)	F	22	-	56	6.1
Main St. Proj IPDA	M/F	20	-	NA	12-24 hrs
Residential Treatment					
AFM: Compass (Southport)	Youth, M/F	14	5.3	27	33
AFM: Women's (Winnipeg)	F	24	168 ²	74	20
AFM: Men's (Winnipeg)	M	38	27 ³	58	25
AFM: Parkwood (Brandon)	M/F	20	M- 88, W- 88	83	18
AFM: Willard Monson House (St. Rose)	M/F	22	M- 71, W- 81	90	18
AFM: Eaglewood (Thompson) ⁴	M/F	24	M- 71, W- 71	78	25
Behavioural Health Foundation	M/F	110	M – 24, W - 62 ⁵	93 ⁶	M-89, F-93 Breezy-62
Native Addictions Council	M/F	22	Varies due to program cycle	92	NA
Salvation Army Anchorage Program	M/F	32	90	70	90
Tamarack Recovery Centre	M/F	12	M- 14, W- 15	69	70
Rosaire House (The Pas)	M/F	16	45	95	28
Supportive Recovery (After care)					
Esther House	F	6	Entry direct from treatment	NA	150
River Point Centre (AFM)	M/F	30	45	Est. 100	NA
Main Street Project Supportive Housing (Mainstay)	M/F	34	140	Est. 100	NA
Bell Hotel – (Main Street) ⁸	M/F	42	NA	100	NA
Addiction Recovery Inc.	M	14	59 ⁷	92.1 ⁷	257
Two Ten Recovery	M/F	25	Depends on release from previous program	80-95	M-135, W-270

¹ LOS varies as clients may stay up to 10 days awaiting a treatment space

² In addition to an average 36 day wait for an intake/assessment

³ In addition to an average 11 day wait for an intake/assessment

⁴ Includes 4 non-medical WMS beds for which wait time, LOS and occupancy could not be reported on separately

⁵ Includes Breezy program for women

⁶ Fluctuates with participation of children

⁷ Bed often held for release from corrections or AFM

⁸ Operated by Main Street Project for the WRHA

Table 7 reports wait times for Manitoba’s community-based mental health programs, offered by the RHAs, including Psychiatry and Psychology consults, as well as a variety of contracted service providers. This covers a very wide spectrum of service modalities and their population target groups, which poses major challenges in comparability and interpretation. Importantly, the distinction between urgent and non-urgent situations is not possible to maintain consistently in this broad review wait times and involving so many organizations with differing approaches to documentation. It is also challenging to reduce the services to a common metric although we have attempted to equate most reported wait times to the number of weeks⁹⁹.

For the RHAs, a fair summary would be that access to community-based services is generally in weeks, if not months, typically ranging between 5 to 10 weeks. A median wait time was estimated for the WRHA services, excluding Psychiatry and Psychology consults, and also excluding any wait times designated as urgent in the information provided. This median time was 6 weeks. Notable exceptions to the median included the community mental health services at PMH and NHR, reported to be 2 weeks.

For WRHA Psychiatry Central Intake, the median for “Triage Wait Time”, which refers to the time of referral to the decision to treat, was 10.9 weeks or about two and half months. The Consult Wait Time, which refers to the time between the decision to treat and the consultation, was 12.6 weeks (combining the information from the HSC (13.9 weeks) and that for St. Boniface Hospital (9.4 weeks)). The waiting periods are said to be a function of a variety of factors, included but by no means limited to high volumes, and time available from both administrative and nursing staff for intake, triage and “decision to treat” points.

Aggregating data for WRHA Psychology was complicated by the distinction between urgent and non-urgent consultation, although this major difference did not appear to be reflected in the actual data, as well as reporting across adult, children and youth and geriatric programs. There was too little data for the geriatric program to report on wait times reliability. A median was calculated for adult and child services, the former coming out to 4 weeks and the latter 12.6 weeks. Importantly, the data shown are for mental health-related services only but do not include services provided outside the WRHA. However, not all WRHA Psychology services report into the Patient Access Registry Tool (PART), nor does it include wait times for those coded as having an explained delay, for personal or medical reasons. Therefore, the data do not provide a full picture, although they are reported useful for monitoring and planning purposes.

⁹⁹ To be consistent in our approach, when wait times were reported in days the Consultant Team divided the number of days by seven days, rather than 5 business days. To the extent that organizations use business days as the denominator the approach here will yield a conservative estimate of wait times as expressed in weeks. .

Table 7. Wait Time for Accessing Manitoba's Community Mental Health Services, 2016/17

Type of Service	Wait Time
Regional Health Authorities	
WRHA	
Walk in	16 min- registration to screening
CMH Access Coordination	10.3 weeks
CODI, EPPIS, MH Court Forensics, PACT	Varies according to status - urgency, primary or basic
Geographic Based CMH Services	1.4 weeks-varies according to urgency
Shared Care Counsellors	5.4 weeks
Shared Care Psychology	10.3 weeks
Shared Care Psychiatry	7.8 weeks
Psychiatry Triage	10.9 weeks (median)
Psychiatry Consults	12.6 weeks (median)
Psychology (adult)	4 weeks (median)
Psychology (child)	12.6 weeks (median)
IERHA	
Adult	7.7 weeks
Elderly	6.6 weeks
Child and Youth	N/A
PMH	
Adult Community Mental Health	2 weeks
SS-SS	
Adult	7.7 weeks
Elderly	2 weeks
Child and Youth	4 weeks
ICM	0
Eden Outpatient	
Urgent	within 2 weeks
Non-urgent	within 8 to 12 weeks
NHR	
Community Mental Health	2 weeks
Contracted Mental Health Services	
The Laurel Centre	
Outpatient Community Services	137 weeks (about 2.6 years)
Male Child Sexual Abuse Program	106 weeks (about 2 years)
Short term therapy	20 weeks (about 5 months)
Klinik	
Long term counselling	One year or more
Drop-in counselling and speciality clinics	No wait time
CMHA Thompson	No wait time for community services

Type of Service	Wait Time
CMHA Swan Lake	Reported in PMH service information
CMHA Manitoba and Winnipeg	Varies depending on location of services; typically less than a week
CMHA Interlake	
Portable Housing benefit	2-8 weeks
Supported Housing	4-8 weeks
Other community services	Varies depending on service
ADAM	Varies depending on location and service; typically less than a week
MDAM	Varies depending on location and service; typically less than a week
OCD	OCD programming: no wait. Hoarding workshops: depending on funding
Manitoba Schizophrenia Society	No information provided

With respect to Manitoba’s inpatient mental health services, the Consulting team was challenged to identify and synthesize, in a meaningful way, all the required information concerning operating characteristic such as wait times, occupancy rates, length of stay (LOS) and patients deemed as requiring Alternative Level of Care (ALC). The term ALC means a person is occupying a bed at a particular level of care because there is no service currently available at the level of care deemed to be most appropriate. In other words, the person is in a “holding position”. The following was gleaned from the information provided:

- Occupancy rates for the province’s CSUs ranged from 98% for the WRHA, to 41% for SH-SS. In between fell the rates for IERHA adult at 63% and PMH Child and Youth CSU at 78%. Wait times were insignificant at the province’s CSUs
- In terms of ALC, Eden reported, 6 of their 30 patients (24%) were designated as ALC in 2016/17. For SMHC, the percentages of patients in ALC status differed significantly by program:
 - Acute – 2%
 - ABI - 9.1%
 - Rehabilitation – 17.4%
 - Geriatric - 41.3%

Although ALC data were not available in a comparable format for the province’s acute care psychiatric inpatient services a request to the RHAs¹⁰⁰ for information revealed that ALC was viewed a significant challenge. The number of ALC days for individual patients reached

¹⁰⁰ The request did not go to IEHRA or SS Sud since their inpatient acute care services are provided by SMHC and Eden Mental health Centre, respectively.

between 100 to 250 or more days, in some extreme instances. The reasons reported were multiple and often complex, with the most common factors being limited access to various types of community housing as well as limited availability of the services required in order to transfer the patient. Examples given included:

- Very lengthy wait for rehab beds at SMHC
- Wait for space in Personal Care Homes
- Wait for housing due to being homeless
- Wait for housing in mental health residential care
- Wait for specialized housing (e.g., wheelchair accessible, group home placement)

While challenges were identified across all the regions, the feedback from the NHA reflected particularly difficult challenges due to the very limited housing options available as well as the general lack of community supports for people coming from remote communities and otherwise being ready and prepared to return home.

Wait times varied significantly by program at SMHC and by gender. For DBT, Geriatric, and Rehab programs, the wait times ranged from 168 days for males for DBT to 334 days for females for Rehab. The wait list for SMHC Forensics is coordinated with the WRHA Forensic Mental Health Program. It was reported that no wait list is kept for inpatient services at Eden Mental Health Centre.

6.3.2 Service Utilization

A significant aspect of the data request submitted to the many participating organizations concerned caseloads, and to the extent possible, a breakdown by region of clients' residence so as to compare current service capacity with the projected need at a provincial, as well as a regional level. In addition, the data request stipulated a gender breakdown as well as age ranges that would allow comparison to available population estimates of need. Lastly, participants were asked to allocate clients according to a pre-identified set of service categories that would illustrate service utilization in different settings and ultimately support of need according to level of care. An "unduplicated" count of individuals treated across the various service categories was also requested to help determine system "coverage" at a high level.

Not surprisingly, given previously identified concerns with the disparate information systems within and across the many participating service providers, and across SUA/MH services in particular, significant challenges were experienced in meeting the "ideal" data collection expressed above. As noted in the methods section, fewer challenges were identified aggregating the data provided by the SUA service providers given the consistency that comes with services being delivered by, and reporting to, common systems within the AFM. In addition, all SUA in the province report standardized information to the National Treatment Indicators project of the Canadian Centre on

Substance Use and Addiction, facilitated by MHSAL staff who also supported the present system review.

Table 8 provides a synthesis of the service utilization statistics gathered by the Consultant Team for SUA services. This synthesis represents a robust estimate of the number of people 15 years of age and older who are utilizing Manitoba’s publicly funded SUA services and is supplemented with additional caseload data from hospital inpatient statistics, physician medical claims and data submitted from the RHAs (e.g., services such as emergency departments and crisis services), SMHC and the many contracted community service providers. Interestingly, far more people with SUA challenges are utilizing physician and hospital services, including EDs and crisis, than the more “specialized” services, such as residential treatment and outpatient counselling.

The columns in Table 8 represent the regional breakdown based on reported region of residence. The row at the bottom of the table represents the best unduplicated count possible, recognizing that it is just that—an estimate. While all caseload duplication was removed between the hospital discharge data and the medical billing claims, there will no doubt be overlap with ED utilization statistics and, to a lesser extent, crisis services. Other factors, however, contribute to these being an underestimate of service utilization, for example, medical claims and hospital discharges will count only diagnosed cases.

Table 9 is a somewhat similar table, also organized regionally and aiming for an unduplicated total case count as the bottom line. In this instance, however, the data represent the COMBINED totals for people with SUA/MH¹⁰¹. Given this wider scope, the data are drawn from a correspondingly wider network of services, including the full scope of the RHA mental health services, SMHC, Eden, and a range of other contracted providers. Widening the scope has its advantages in terms of mapping the full extent of involvement of people in need with these publicly funded services, but also disadvantages in that there is more variation in information systems and documentation (e.g., across the grant-funded agencies) and more room for duplicate counting. In the end, as with Table 8 focused on SUA services, the estimates provided here need to be interpreted cautiously.

Table 9 is divided into two parts – the upper half focused on residential services, followed by non-residential services, including physician services, and, at the bottom of the Table, emergency and mobile and other crisis services. Similar to what was observed for SUA services, a significant majority of service utilization events are with physicians (55% of the unduplicated count). This will include, but not be limited to, psychiatrists, presentations to

¹⁰¹ The reason data were collected separately for SUA services and then for combined SUA/MH is because of the availability of population need estimates for SUA challenges separately and for SUA/MH combined. While both estimates will be of interest in this system review, the combined total are presented in the spirit of developing a more integrated SUA/MH system in Manitoba and an integrated Strategy.

ED and engagement in crisis and hospital inpatient services (combining for another 18.6%).

Tables 10 and 11 follow suit, and are based on children and youth under the age of 18 who utilized services for SUA challenges (Table 10) and, in Table 11, the combined case count for SUA/MH challenges.

Table 8. Adults (15+ years) Substance Use Service Utilization, Estimated Annual Caseload 2016-2017, by Region of Residence

Type of Service	Region of Client Residence					
	IERHA	NRHA	PMH	SH-SS	WRHA	Total
Withdrawal Management						
Acute Intoxication ¹	-	-	-	-	2,525	2,525
Community Residential WMS ²	4	36	1	-	1,179	1,220
Complexity Enhanced/Hospital Based WMS ³	-	-	-	-	264	264
Residential Services						
Stabilization/Transitional ⁴	-	-	-	-	57	57
Supportive Recovery ⁵	-	-	-	-	174	174
Community Intensive Residential ⁶	250	579	288	122	1,069	2,308
Hospital/Complexity Enhanced Residential ⁷	37	8	5	8	38	96
Non-Residential Services						
Outreach - Feedback and Engagement (e.g. Harm Reduction, etc.) ⁸	-	-	-	-	3,396	3,396
Outpatient - Structured Brief Intervention ⁹	393	657	1,077	471	3,222	5,820
Outpatient - Structured Comprehensive Intervention ¹⁰	233	352	809	177	2,699	4,270
Day/Evening - Intensive Complexity Enhanced ¹¹	2	4	18	4	122	150
Non-Specialized						
Hospital Inpatient ¹²	273	-	632	234	1,781	2,920
Physician Services ¹³	613	282	838	336	7,170	9,239
Emergency and Crisis ¹⁴	-	-	1,464	276	4,621	6,361
Community Mental Health	-	-	389	-	93 ¹⁴	482
Total Duplicated Cases¹⁵	1,805	1,918	5,521	1,628	28,410	39,282
Total Estimated Unduplicated Cases	1,498	1,848	4,477	1,372	20,938	30,133

¹ Main Street IPDA

² Main Street, AFM and YASU

³ HSC Medical WMS

⁴ Main Street and selected housing services

⁵ Primarily contracted addiction service providers

⁶ Primarily AFM and contracted addiction service providers

⁷ Selkirk Mental Health Centre

⁸ Primarily Resource Assistance for Youth (RaY) and Klinik

⁹ Primarily AFM and RaY

¹⁰ Primarily AFM and MATC

¹¹ AFM Day Treatment, MATC and contracted addiction agencies

¹² Cases reported in hospital statistics

¹³ Medical claims for addiction (includes ORT)

¹⁴ Primarily ED services and crisis

¹⁵ Duplication removed where possible, may over-estimate service utilization across service providers and/or regions.

Table 9. Adults (15+ years), Mental Health and Substance Use/Addiction Service Utilization: Estimated (Annual Caseload 2016-2017), by Region of Residence

Type of Services		Region of Client Residence					Total
		IERHA	NRHA	PMH	SH-SS	WRHA	
Residential Services	Addictions Withdrawal Management						
	Acute Intoxication	-	-	-	-	2,525	2,525
	Community Residential WMS	4	36	1	-	1,179	1,220
	Complexity Enhanced/Hospital Based WMS	-	-	-	-	264	264
	Addictions Treatment and Recovery¹						
	Stabilization/Transitional	-	-	-	-	57	57
	Supportive Recovery	-	-	-	-	174	174
	Community Intensive Residential	250	579	288	119	1,076	2,312
Hospital/Complexity Enhanced Residential	37	8	5	8	38	96	
	Hospital Inpatient²	1,367	751	1,302	710	4,211	8,341
	Community Mental Health³	-	116	48	8	411	583
Non-Residential Services	Community Treatment and Support⁴						
	Outreach - Feedback and Engagement (e.g. Outreach, Harm Reduction, etc.)	-	-	-	-	6,792	6,792
	Outpatient - Structured Brief Intervention	393	657	1,077	471	3,381	5,979
	Outpatient - Structured Comprehensive Intervention	2,672	3,868	2,129	287	5,459	14,415
	Day/Evening - Intensive Complexity Enhanced	2	4	18	4	122	150
	Community Non-Residential Mental Health	2,877	4,845	7,506	6,622	14,954	36,804
	Physician Services⁵	7,679	2,092	15,157	6,569	102,410	133,907
Emergency and Crisis							
	Emergency	536 ⁶	-	1,601	552	9,587	12,276
	Mobile/Other Crisis ⁷	1,450	159	1,449	1,000	20,516	24,574
Total Duplicated Cases⁹		17,267	13,115	30,581	16,350	173,156	250,469
Total Estimated Unduplicated Cases		15,010	12,085	28,935	16,212	169,975	242,217

¹ Includes both treatment and recovery/aftercare service

² Inpatient psychiatry and other hospital bed utilization

³ Mental health residential care and various housing services

⁴ Includes community mental health and outpatient/community addictions

⁵ Medical claims for mental health and addiction (includes ORT)

⁶ Emergency liaison only

⁷ Include inpatient crisis stabilization

⁸ Main St. Men's and Women's including IPDA

⁹ Duplication removed where possible but may still over-estimate service utilization across service providers and/or regions.

Table 10. Youth (≤17 years) Substance Use Service Utilization, Estimated Annual Caseload 2016-2017, by Region of Residence

Type of Service	Region of Client Residence					
	IERHA	NRHA	PMH	SH-SS	WRHA	Total
Withdrawal Management						
Acute Intoxication ¹	-	-	-	-	132	132
Community Residential WMS ²	-	-	-	-	138	138
Complexity Enhanced/Hospital Based WMS	-	-	-	-	-	-
Residential Services						
Stabilization/Transitional	-	-	-	-	-	-
Supportive Recovery	-	-	-	-	-	-
Community Intensive Residential ³	10	9	5	11	40	75
Hospital/Complexity Enhanced Residential	-	-	-	-	-	-
Non-Residential Services						
Outreach - Feedback and Engagement (e.g. Outreach, Harm Reduction, etc.)	-	-	-	-	-	-
Outpatient - Structured Brief Intervention	82	76	117	99	467	841
Outpatient - Structured Comprehensive Intervention ³	53	26	71	53	197	400
Day/Evening - Intensive Complexity Enhanced ¹²	-	-	-	-	-	-
Non-Specialized						
Hospital Inpatient ⁴	12	29	22	6	61	130
Physician Services ⁵	17	26	23	12	125	203
Emergency and Crisis ⁶	-	-	-	59	272	331
Community Mental Health	-	-	48	-	-	48
Total Duplicated Cases⁷	174	166	286	240	1,432	2,239
Total Estimated Unduplicated Cases	136	133	239	224	1,289	2,021

¹ YASU-IPDA

² AFM and MATC

³ AFM

⁴ Cases reported in hospital statistics

⁵ Medical claims for addiction

⁶ Primarily ED services and crisis

⁷ Duplication removed where possible, but may still over-estimate service utilization across service providers and/or regions.

Table 11. Youth (≤17 years), Mental Health and Substance Use/Addiction Service Utilization: Estimated Annual Caseload 2016-2017, by Region of Residence

Type of Service		Region of Client Residence					Total
		IERHA	NHR	PMH	SH-SS	WRHA	
Residential Services	Addictions Withdrawal Management						
	Acute Intoxication	-	-	-	-	132	132
	Community Residential WMS	-	-	-	-	138	138
	Complexity Enhanced/ Hospital Based WMS	-	-	-	-	-	-
	Addictions Treatment and Recovery¹						
	Stabilization/Transitional	-	-	-	-	-	-
	Supportive Recovery	-	-	-	-	-	-
	Community Intensive Residential	10	9	5	10	36	70
	Hospital/Complexity Enhanced Residential	-	-	-	-	-	-
	Hospital Inpatient²	63	108	22	44	283	520
Community Mental Health	-	-	-	-	-	-	
Non-Residential Services	Community Treatment and Support³						
	Outreach - Feedback and Engagement (e.g. Outreach, Harm Reduction, etc.)	-	-	-	-	-	-
	Outpatient - Structured Brief Intervention	82	76	118	100	2,305	2,681
	Outpatient - Structured Comprehensive Intervention	53	26	70	877	183	1,209
	Day/Evening - Intensive Complexity Enhanced	-	-	-	-	-	-
	Community Non-Residential Mental Health	534	-	1,593	-	-	2,127
Physician Services⁵	416	391	1,202	441	4,802	7,252	
Emergency and Crisis							
Emergency	-	-	-	63	1,559	1,622	
Mobile/Other Crisis ⁶	283	134	257	97	-	771	
Total Duplicated Cases⁹		1,441	744	3,267	1,632	9,438	16,522
Total Estimated Unduplicated Cases		1,352	678	3,209	1,613	9,068	15,960

¹ Includes both treatment and recovery/aftercare service

² Inpatient psychiatry and other hospital bed utilization

³ Includes community mental health and outpatient/community addictions

⁵ Medical claims for mental health and addiction

⁶ Include inpatient crisis stabilization

⁷ Duplication removed where possible, may over-estimate service utilization across service providers and/or regions.

Information was also gathered through the data request on crisis contacts and helpline calls. A decision was made not to include these data in the above counts, primarily because of the deliberately anonymous nature of the contacts and the potential for multiple counting of the same person. Often information may not be captured about the nature of the situation with respect to SUA/MH. This is not in any way meant to diminish the importance of these contacts and the numbers in Table 12 speak to the amount of support that is being offered through these services. These high numbers should also be taken as an underestimate since not all regions were able to provide the required data.

Table 12. Estimated Contacts through Crisis Phone Lines and Help Lines

Type of Support	Number of Calls
RHA-based	
WRHA	Not Applicable
NHR	Not Applicable
IERHA	10,138
PMH Adult	Data not available
PMH Youth under 18	839
PMH Adult and Youth Crisis Line North	Data not available
SH-SS (Eastern half of SH-SS)	1,068
Klinik-based	
Sexual Assault Crisis Line	2,533
Crisis Line	36,279
Manitoba Suicide & Support Line	3,796
Worker's Compensation Board Line	1,062
Senior's Abuse & Support Line	279
MB Farm Rural & Northern Support Service	1,095
Chat Services	489
AFM	
Provincial Adult Addictions Information Line	2,672
24-hour Problem Gambling Helpline	1,325

Table 13 tabulates another form of support that is also not counted in the formal “individual counts” of Tables 8 to 11, namely the wide variety of contacts to many organizations for information, system navigation and education. These contacts may be by phone, email, and/or face-to-face, and the Consultant Team made an effort to distinguish these contacts from those contacts which are more support-oriented. This is admittedly a grey area. Because of the way these contacts are recorded by the various organizations represented in Table 13, they cannot in any way be taken to represent unique individuals.

Table 13. Estimated Number of Additional Contacts for Information, System Navigation and/or Education.

Organization	Number of Contacts
AFM Public Education	42,572
CMHA Thompson	NA
CMHA Swan Valley	NA
CMHA Winnipeg	6,022
CMHA Interlake	NA
MDAM	15,461
ADAM	6,980
OCDC	NA
Manitoba Schizophrenia Society	NA
Art Beat	11,421

6.3.3 Quantitative Assessment of System Coverage

6.3.3.1 Methods

The quantitative assessment of system coverage involved three steps:

- Step 1: Estimating need for treatment and support on the basis of the best available population data for SUA/MH challenges (i.e., prevalence)
- Step 2: Estimating current system capacity (i.e., service utilization)
- Step 3: By division, determining the treatment coverage expressed as the Prevalence-Service Utilization Ratio (PSUR) (i.e., prevalence/service utilization)

Step 1: Estimating need for treatment and support

Given the requirement for the provincial Strategic Plan to include adults as well as children and adolescents, it was necessary to undertake this step separately for the two sub-populations.

Adults: Prevalence data for adults are available from two alternative and complementary sources.

The first source of information is the recent study by the Manitoba Centre for Health Policy (MCHP)¹⁰² that provides estimates of the “diagnostic prevalence” of mental disorders, including substance use disorders, for the Manitoba population 18 years or age and over and by gender. These data cover almost the full range of mental and substance use disorders and are supplemented with population rates of suicide and hospitalizations

¹⁰² Draft of Executive Summary of the MCHP report Mental Illness among Adult Manitobans, due for release in 2018 and provided to the VIRGO consultant team for purposes of this report. to documents.

for attempted suicide. The main disadvantage for present purposes is that there will be significant under-estimation of need since being included for purposes of prevalence estimation depends on the person seeking help from a health professional who is qualified to give a diagnosis and, further, that existing mental and substance use disorders will in fact be identified and recorded through proper screening, assessment and documentation. Also, the approach requires the selection of a time period for analysis, in this case, a five-year period, so the researchers can accumulate enough cases for a reliable estimate. This yields an estimate of five-year period prevalence which would be contrasted with one-year service utilization data for the assessment of treatment coverage. This difference is not ideal for system planning. A further challenge is that population data based on diagnostic prevalence do not include information on people who are experiencing significant challenges and who might be considered professionally as needing services and supports and/or who express the need for treatment and support, but who do not meet the criteria for a formal diagnosis. In this regard, it's important to note that many SUA/MH services do NOT require a formal diagnosis to qualify for the provision of services and support (e.g., crisis services, many community mental health services, SUA services). This population is often referred to as those with "sub-threshold" illnesses or, in the more everyday language of the mental health field, the "mild" or "moderate" population. Lastly, diagnostic prevalence data are not yet available by region, an important consideration in the present planning context.

The second source of information on the population-level of need for SUA/MH services in Manitoba is the 2012 Canadian Community Health Survey (CCHS) - Mental Health, a comprehensive household survey covering the population aged 15 and over. Data on the prevalence of mental and substance use disorders, as defined diagnostically, are available for the province through Statistics Canada. Manitoba-specific estimates for the mental disorders covered in the 2012 CCHS - Mental Health Survey have been calculated and made available to the Consultant Team by Dr. Jitender Sareen and colleagues (personal communication).

Going beyond the diagnostic data, however, a more detailed analysis of the 2012 CCHS mental health data for Manitoba and its sub-regions is available through the National Needs-Based Planning Project, a project in which Manitoba is participating as a pilot jurisdiction. The methodological approach in this project has been to define five levels of need with a set of criteria purposefully developed to profile survey respondents in terms of severity and complexity of mental health and substance use/addictions challenges. The five categories of need are based on the respondent's answers to questions about quantity and frequency of alcohol and other drug use, Composite International Diagnostic Interview (CIDI)-based mental health and substance use disorders, perceived need for help, chronic health conditions, suicidal ideation, severity of disability and a small number of other indicators (see Appendix H for the specific criteria for defining the five groupings). The statistical methodology also employed socio-demographic predictors, including age,

gender, immigrant status, and a measure of social deprivation which provides an adjustment for regional context. Membership in each severity tier was estimated for Manitoba as a whole and for each of the five health planning regions. Data were broken down by three age groupings (15 to 25, 26 to 64, and 65 and over) and for men and women, and based on each region's age–gender distribution in 2016. One estimation approach was based on the need for SUA services and another based on the need for SUA/MH services.

As described earlier in [Section 5.1](#) the resulting data can be displayed as a population health pyramid with a small percentage of the population at the top of the pyramid experiencing very significant and complex needs, and a much larger percentage at the bottom with less severe or no needs at the present time. Consistent with the conceptual framework shown earlier in Figure 1 this allows for a mapping of need onto a stepped or “tiered model” of a treatment system¹⁰³.

Although the Needs-Based Planning approach has significant advantages for planning purposes it also has limitations. It is limited, in part by the fact that the underlying survey data are based on self-report, for example, alcohol and drug use and symptoms of mental illness, as opposed to diagnostic approaches for which one can assume a certain level of standardization in professional decision-making. In addition, the survey does not include all mental disorders, for example, personality disorders and neuro-developmental disorders such as autism are not included. That being said, the CCHS Mental Health Survey is based on sophisticated, internationally accepted methods to derive the diagnostic data of the most common disorders and, overall, the survey information is designed to be useful for planning purposes. A further limitation, however, is that important segments of the Canadian population are not included in the national survey, including Indigenous people living on reserve, the homeless and those institutionalized (such as in a correctional facility) at the time of the survey. Exclusion of Indigenous people on reserve from the national survey is of course a very important limitation, especially in the Manitoba context. Importantly, Manitobans living on reserve are included in the resulting population pyramid for Manitoba, and the five Regional Health Authorities (RHAs). However, their needs will be under-estimated to the extent that their severity profiles do not match that of other Manitobans engaged in the national survey.

¹⁰³ For SUA services specifically, the methodology of the National Needs-Based Planning project goes further to estimate required service capacity of specific service categories such as withdrawal management, community-based counselling and residential treatment. This work, however, is still under development and reported separately in the context of Manitoba's involvement as a pilot site.

While both available methods for estimating the need for SUA/MH services and supports in Manitoba have their strengths and limitations, the primary approach to be followed is based on the provincial and regional projections derived from the CCHS Mental Health survey and a second complementary comparison made using the five-year diagnostic prevalence data recently made available to the Consultant team from the MCHP.

Children and adolescents: As is the case with adults, two alternative sources of information are available to estimate the population-level of need for mental health and substance use/addiction services in Manitoba for children and adolescents.

The first approach is based on diagnostic prevalence using procedures similar to that described above for adults, and available in a separate MCHP report for children and youth up to and including the age of 19, and for 2012-13.¹⁰⁴ Advantages and disadvantages are also similar to those identified above for the adult diagnostic prevalence data, for example, the underestimation of need in rural and remote areas of the province since inclusion depends on having seen and been given a diagnosis by a qualified health professional. Advantages include the wide range of mental illnesses covered in the survey, in particular a wide range of anxiety disorders, and the specificity of the information to Manitoban children and youth. Disadvantages include the present lack of regional-level data and the age cut-off for data collection and analysis at age 19 and under, which does not provide a close parallel to the formally mandated age cut-offs for service delivery (under age 18).

Unfortunately, in contrast to the situation with the available adult data, there is no available population health data for children and youth that allow for an estimation of need using the population-health pyramid approach. However, another source of diagnostic-based data comes from a published international synthesis of the best children and youth mental health epidemiological surveys¹⁰⁵ and which allows for projections of service needs for Manitoba as a whole, as well as for each of its five RHAs. In addition, the resulting data correspond to the age category under 18, which maps on to the current age cut-off for children/youth services versus adult services in the province. This facilitates application of the data for planning purposes. The main disadvantage of this approach is a more limited range of mental disorders covered in the research synthesis and resulting projections to Manitoba, for example, a more limited range of anxiety disorders. In addition, although included in the overall population estimates, the needs of Indigenous

¹⁰⁴ Chartier, M., Brownell, M., MacWilliam, L., Valdivia, J., Nie, Y., et al., (2016). *The mental health of Manitoba's children*. Winnipeg, MB. Manitoba Centre for Health Policy.

¹⁰⁵ Waddell, C., Shepherd, C., Schwartz, C., & Barican, J. (June, 2014), *Child and youth mental disorders: Prevalence and evidence-based interventions*. Children's Health Policy Centre, Simon Fraser University, British Columbia.

children and youth will be under-represented to the extent their needs are more severe and complex.

As with the adult population, the approach is to contrast the results based on estimates of need projected from the best available international literature to the estimates of need derived from the work of the MCHP.

Step 2: Estimating current system utilization

A synthesis of current service utilization for SUA/MH challenges was developed using information from the “data request”, organized to the extent possible by region, age and gender of the population served. Information was summarized separately for adults 15 and over (to correspond to the population pyramid derived from the CCHS Mental Health survey data) and for children and youth up to and including age 17 (to correspond to the projections based on the Manitoba projections derived from the international survey estimates).

Data were requested on annual service utilization from the RHAs, SMHC, MATC, Eden Mental Health Centre, AFM and relevant government-funded service providers. The request asked for information across the full continuum of services being offered and as shown above in Tables 8-11 with the aim being to obtain an unduplicated count of people accessing services on an annual basis. During the data collection process, the Consultant Team was apprised by representatives of several organizations involved in supporting the data request that issues related to information systems and data management precluded full achievement of this goal. While some challenges were due to the time frame required for return of the requested information, the majority of the issues encountered reflected limitations of the information systems themselves. The following are the main issues encountered in data completeness and quality and which need to be taken into account in interpreting the results. Challenges included:

- Some organizations’ systems were still paper-based and/or the information systems were being revamped and historical data were not readily available.
- Ability to report service utilization for some but not all services provided.
- Variation in how region of client/patient was recorded, if available at all, or organizations still recording their statistics either using previous RHA boundaries or something unique to their own service.
- Challenges retrieving information related to use of specific services, for example, emergency services or some crisis services for reasons related to SUA/MH challenges.
- Inability to provide any breakdown by age or gender of the person seeking assistance, or variability in the age ranges of information routinely compiled.

- Reporting of calls/contacts to crisis and helplines which are intentionally anonymous.
- Several organizations engage in significant outreach to communities through workshops and presentations, and respond to requests for information and/or assistance with navigating the system (e.g., Mood Disorders Association of Manitoba (MDAM); Anxiety Disorders Association of Manitoba (ADAM); Manitoba Schizophrenia Society (MSS)). There is a grey area here in terms of provision of intervention and support versus information only. In addition, to the extent people follow through and engage with more formal services, a significant but unknown number of these information-only contacts will be duplicated in the caseload data.
- Exclusion of data from FNIH-funded organizations, other departments of the Manitoba government such as Manitoba Justice, Manitoba Education and Training, and the Department of Families.

As noted earlier, more consistent information of service utilization was available for the utilization of Manitoba's substance use/addiction services since the vast majority of services are provided through AFM and, therefore, have common reporting guidelines. As a result more finely grained estimates are possible when the analysis is restricted to SUA services, including estimates of treatment coverage by region and for different age groups (shown in Appendix I and J).

Calls/contacts with crisis services and helplines, as well as email, phone and other contacts for information and brief support (shown previously in Tables 12 and 13) are not included.

Step 3: By division, determine the treatment coverage expressed as the Prevalence-Service Utilization Ratio (PSUR) (i.e., need/current utilization)

This step involves the comparison of the need for treatment and recovery support as derived from Step 1 above and the current utilization of the system obtained in step 2. Given the information available on wait times for services in Manitoba this descriptive analysis is based on the assumption that current service utilization is a reasonable approximation of current capacity.

Given the current configuration of services in Manitoba, and the goal for a comprehensive Strategic Plan inclusive of both SUA and mental health services, treatment coverage was calculated separately for SUA services and then for SUA/MH combined. In each instance the analysis was conducted separately for adults (15 and over), and for children and adolescents (under 18).

Where possible, comparisons are made between the information derived from the different sources of population estimates of need as outlined in Step 1.

6.3.3.2 Results of the coverage assessment: Adults 15 and over

Figures 19 and 20 show the resulting population health pyramids for Manitobans 15 years of age¹⁰⁶; Figure 19 reflecting SUA and Figure 20 SUA/MH. Looking first at the distribution of need for SUA services (Figure 19) the percentage in Tiers 4 and 5, which correspond to the highest levels of need, is a combined 6.3% which approximates the diagnostic prevalence rate reported by the MCHP. Below this level of need, however, is another 15.9% in Tier 3 also with significant SUA challenges for a combined level of need of 22.2% from Tiers 3-5. Going still further to include Tier 2, an additional 36.9% of the population is included, a significant segment of the Manitoba population. Drinking alcohol at levels beyond the low risk drinking guidelines no doubt accounts for a significant percentage of this group, a finding validated recently by the MCHP report showing 15.1% of females and 20.6% are drinking above this guideline. This large population is appropriate for evidence-based screening and brief intervention in primary care and other settings. An important limitation should be noted with respect to Tier 2 such that many individuals accessing helplines and no doubt other “low threshold” services that are not included in our coverage estimates such as, street outreach or phone/email provided by the MDAM, are probably receiving a form of “brief engagement and advice”. This will lead to an underestimate of the overall system coverage.

¹⁰⁶ Population size was estimated at 1,071,004

Figure 19. Substance Use/Addiction Population Health Pyramids for Manitoba Adults, 15+ and over

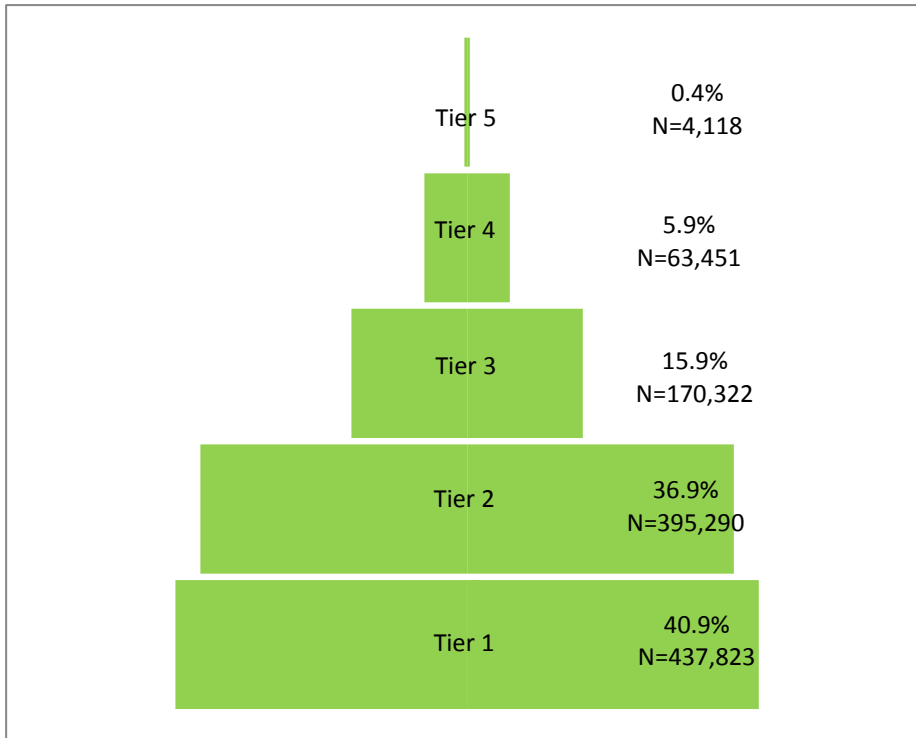
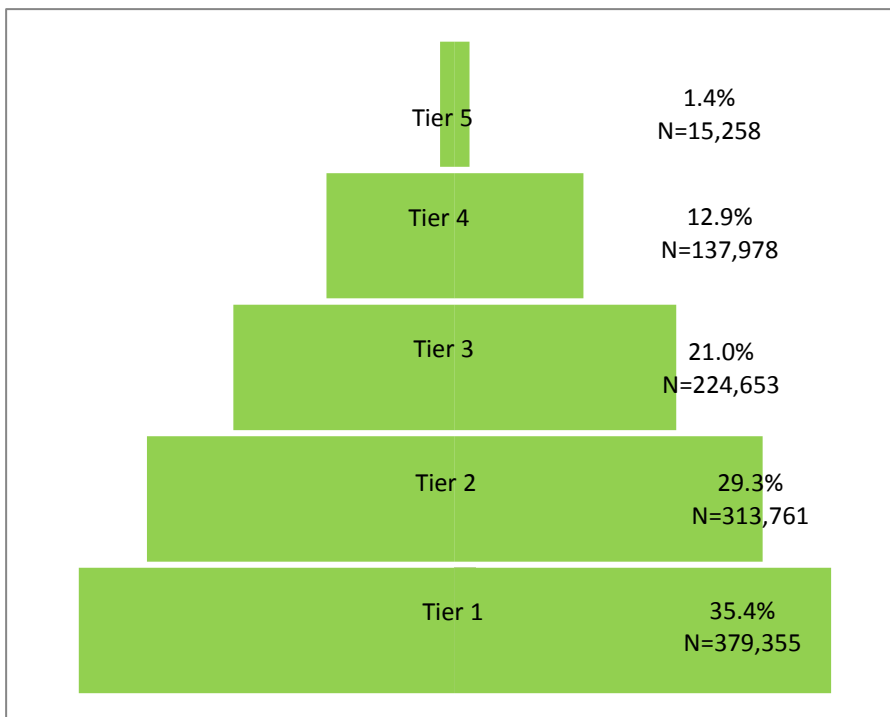


Figure 20. Mental Health & Substance Use/Addiction Population Health Pyramids Manitoba Adults, 15+ Over



With respect to Figure 20 which shows the distribution of need for SUA/MH combined, the estimate of the top two severity tiers combined is 14.3% and, when combined with Tier 3, a total of 35.3% is obtained or about 1 of every 3 Manitobans in this population group. This corresponds reasonably closely to the five-year diagnostic prevalence estimate from the MCHP of 30-35%. Factoring in Tier 2, however, adds another 29.3% of Manitobans 15 years of age and over, who are experiencing less severe challenges but who could also benefit from some brief advice or self-management resources.

In interpreting these data and their implications for strategic planning it is important to keep in mind the limitations of the national survey on which they are based, for example the limited range of mental disorders included (e.g., personality disorders, bipolar disorder) and the exclusion of Indigenous people on reserve as well as people who are homeless or living in institutions. The net effect of these limitations is such that the need estimates presented here are probably an under-estimate of the distribution of need for SUA/MH services in the province. From a planning perspective, and given scarce resources, it is preferable to be erring on the side of being conservative rather than over-estimating on the assumption that it is easier to scale services up rather than have unused resources in the system. Another important factor to take into account in system planning is that one would not expect 100% of the in-need population to access services in the same year due to factors such as stigma and discrimination, practical challenges such as transportation and child care, the belief one can handle these challenges without professional help and, of course, the availability and accessibility of services. We return to these issues below and turn now to the assessment of treatment coverage based on current utilization of services.

Assessing system coverage: The next step in the analytic process was to compare the above data on estimated need to actual service utilization. In Tables 14 and 15, the level of coverage of the system of services is estimated, first for SUA and then for SUA/MH. The estimate of coverage is shown in two ways – first combining the need estimates for severity Tiers 3-5, and comparing to current capacity as estimated in Tables 8 and 9, using the unduplicated counts; and then deriving an estimate of coverage based on the full range of need, that is including Tier 2. The first estimate is more conservative and recognizes that the current service delivery system is not well-oriented to serve people of lower need, but is still highly relevant for strategic planning as it illustrates the importance of early intervention and self-management approaches.

Table 14 shows the estimate of current coverage for SUA challenges to be 12.6%, based on Tiers 3-5 and 4.8% if the full range of need is included from Tiers 2- 5. Table 15 shows a much higher level of current coverage for SUA/MH combined at about 64%, when calculated for Tiers 3-5, and 35% for the full spectrum of need including Tier 2.

The final step in the analysis, before turning to children and adolescents, was to draw a comparison with the other available estimate of need for SUA/MH services for Manitoban adults. In Table 16, the estimates from the tiered model are contrasted with the estimate based on the five-year diagnostic prevalence rate of substance use disorders recently reported by the MCHP – 5.88%, aged 18 and over. We apply this estimate to the population 15 and over as our best approximation and, for SUA, derive an estimate of need of 62,975 people and a corresponding coverage of 47.8%. For SUA/MH the overall estimate of coverage is 75% compared to the lower estimates based on the tiered model (e.g., 35% based on Tiers 2-5).

Clearly the estimates of coverage based on the diagnostic data are significantly higher than those obtained with the tiered data from the CCHS survey because inclusion in the numerator (i.e., prevalence) is based solely on having received a diagnosis by a qualified health professional. People experiencing a lower level of need, or not able to access such a qualified professional, are therefore excluded.

Table 14. Estimated Coverage of SUA Services for the Manitoba Population Aged 15 and Over.

Tier	Percentage in need	Estimated number of individual in-need
5	0.4	4,118
4	5.9	63,451
3	15.9	170,322
2	36.9	395,290
1	40.9	437,823
*Tiers 3-5	35.3	237,891
**Tiers 2-5	72.2	633,181

* In-need: 237,891	Current services: 30,133	Coverage: 12.6%
** In-need: 633,181	Current services: 30,133	Coverage: 4.8%

Table 15. Estimated Coverage of SUA/MH Services for the Manitoba Population Aged 15 and Over.

Tier	Percentage in need	Estimated number of individual in-need
5	1.4	15,258
4	12.9	137,978
3	21.0	224,653
2	29.3	313,761
1	35.4	379,355
*Tiers 3-5	35.3	377,889
**Tiers 2-5	72.2	691,658

* In-need: 377,889	Current services: 242,217	Coverage: 64.1%
** In-need: 691,658	Current services: 242,217	Coverage: 35.0%

Table 16. Summary Chart Comparing Need, Service Use and Coverage across Two Data Sources

	Need	Service Use	Coverage
SUA			
Tiered Model			
Tiers 3-5	237,891	30,133	12.6%
Tiers 2-5	633,181	30,133	4.8%
MCHP (Diagnostic Prevalence - 5.88%)	62,975	30,133	47.8%
SUA/MH			
Tiered Model			
Tiers 3-5	377,889	242,217	64.1%
Tiers 2-5	691,658	242,217	35.0%
MCHP (Diagnostic Prevalence 30%¹)	321,301	242,217	75.0%

¹ The adult prevalence rate of any mental disorder was adjusted to include substance use disorders but reduced by half of the rate of substance use disorders as an adjustment for co-occurring disorders.

6.3.3.3 Children and Youth 17 Years of Age and Under

The gap analysis procedure is much less complex for children and youth since there are no available population health data that allow for the population-health pyramid approach. Using estimates of need from Waddell (and provided in Appendix K) and projected to the Manitoba population, we obtain a prevalence estimate of 2.6% meeting diagnostic criteria for a substance use disorder and 12.6% meeting criteria for any disorder, including a substance use disorder. The corresponding estimates of need shown in Table 16, are contrasted with the estimate of current supply, and yield a coverage rate of 67.8% for SUA and 54.1% for SUA/MH.

As with adults, there was the opportunity to contrast these data with those derived from the MCHP study on Manitoba’s children and youth, also shown in Table 17. Quite similar results are obtained, which is not that surprising since both methods are based on diagnostic criteria alone. Neither approach identifies those who do not meet formal criteria for a mental illness or substance use disorder but who may still need services and support.

Table 17. Estimated Treatment Coverage of Children and Adolescents ≤ 17 years (n = 234,223)

	Need	Capacity	Coverage
SUA (age 11-17)			
Estimated from Waddell (2.6%)	2,983	2,021	67.8%
Estimated from MCHP (Diagnostic Prevalence 2.6%)	2,983	2,021	67.8%
SUA/MH (age 4-17)			
Estimated from Waddell (12.6%)	29,512	15,960	54.1%
Estimated from MCHP (Diagnostic Prevalence 14%)	32,791	15,960	48.7%

6.3.3.4 Interpretation and data limitations:

Estimates of “treatment coverage” require both an estimate of prevalence or need (i.e., the numerator) and an estimate of current service utilization (i.e., the denominator). The challenges with data collection to estimate current levels of service utilization were identified above and certainly highlight the difficulties compiling data from Manitoba’s multiple SUA/MH information systems for planning purposes. With respect to the numerator, a number of challenges were also identified (e.g., exclusion of Indigenous people living on reserve, as well as exclusion of people who are homeless or living in institutions; lack of data for children and youth that represent the full scope of their needs). Together, the data presented above need to be interpreted very cautiously; more like a modelling exercise than a definitive treatment gap analysis and intended to facilitate discussions and implications for system enhancement. In the end, the information presented above must be considered jointly with the qualitative data from the on-line survey, consultations, and validation events. There would also be significant value in fine-tuning the modelling procedure in consultation with Manitoba’s Indigenous people to better reflect their strengths and needs. There would be value also in adapting the model for children and youth in collaboration with the department of Families and other stakeholders.

All this being said, many factors need to be taken into account in interpreting these coverage estimates. Aside from the limitations in the estimates of need (likely an underestimate) there are factors which challenge the estimation of service utilization, most notable the quality of the information available for this exercise, and the many parts of the system not included in the data collection process, for example, FNIH-funded services, and other departments of government. Some limitations with respect to the data consistency in the information collected will lead to an over-estimate of service utilization, for example multiple counting of the same people. Other limitations will have contributed to an under-estimate such as the lack of data from some important services including some ED and crisis services. The exclusion of FNIH-funded services, and those provided by other government departments, will have, in all likelihood, led to significant under-estimation of service utilization, and therefore an under-estimate of coverage.

For a more detailed analysis one would want to drill down to those *components* of the treatment and recovery support continuum that are missing, inaccessible or perhaps over-supplied and showing low occupancy, for example inpatient versus community-based services, medical versus non-medical withdrawal management, screening and brief intervention. The high-level analysis of coverage cannot go that far at the present time although considerable progress is being made in this regard with respect to SUA services.

It would also be ideal to analyse the level of coverage by *severity tier*, but unfortunately this cannot be done accurately since the service utilization data do not reflect the severity of the population accessing these services. One could make assumptions, for example, that those individuals being seen in primary care are more likely to be part of the sub-group in Tiers 2 and 3, but this is an assumption only as we know primary care physicians can and do support people with quite severe challenges. The severity level of those individuals in crisis, or presenting to an ED are likely to be higher, and more representative of Tiers 4 and perhaps 5. However, many people at lower levels of severity also access ED services, for example, following a single alcohol-related accident. With respect to SUA services, one might assume that those individuals in residential treatment are more severe (e.g. Tier 4) than those in community-based services (e.g., Tier 3) although we did hear in the consultation process that many people are mandated to residential treatment who may be equally well-served in community-based services. Further, much of the data from community-mental health could not be separated for sub-groups of services such as intensive case management or less intensive counselling and support groups, so again severity of the actual clients is mixed. Although tempting to conduct exploratory analyses based on these assumptions and nuances in the data they are outside the scope of the current analysis.

Also, in the Manitoba planning context, it would be ideal to have reliable and valid estimates of system coverage on a regional basis and triangulate these estimates with other regional level data. Although this was attempted in the present review, in the end, data challenges precluded presenting these as sufficiently definitive analyses. For example, regional service utilization data were sometimes not available for important services such as ED services or crisis services and their inclusion or exclusion would dramatically change the coverage estimates. The system mapping and qualitative data do inform us, however, about significant challenges with service equity across the regions, with important examples being withdrawal management services, including the complete lack of evidence-based community withdrawal management options, and only one centrally located medical detox unit at the HSC, itself restricted to alcohol and opioid-related WMS. Regional variation in the availability of crisis services is also evident, even within the same RHA (SH-SS)—in the case of mobile crisis services – as well as access to psychiatric assessment. We return to this issue of service equity in sections below that synthesize the results across the various components of the project.

Some interpretations: Despite these observations and limitations some tentative interpretations are warranted and on fairly solid grounds. Based on past history and funding allocations reported earlier in this report, it is likely that people in the large Tier 2 category, are the least well-represented in current services and therefore have the lowest level of coverage. This suggests the need for wide-scale implementation of evidence-based initiatives for screening and brief intervention in primary care and other settings. In addition, these results speak to the need for investing in self-management tools and resources, appropriate for various age groups within this population and including both mobile and Internet-based resources.

With respect to Tier 3, it is also likely that the past history and funding allocations have left the province **under-supplied with resources** appropriate for this level of need. This conclusion is consistent with the feedback from the on-line survey, the consultations and validation events, as well as the wait-time data. For example, stakeholders often reported that their problems needed to get to the point of being in real crisis before they were able to access services, and then still with a **significant wait time**.

Another reasonable conclusion to draw is that, despite the limitations, the data on system coverage point to a **significant shortage of SUA services** specifically. This validates the same observation drawn by David Peachey in his report, and is also supported by much of the qualitative feedback and wait times. The conclusion is also validated by the identification of specific gaps across the entire continuum of SUA services but particularly “high volume” services such as **withdrawal management, ORT and community-based counselling**. We stipulate “high volume” given the service delivery models and since expansion of these types of services would significantly increase the number of people receiving services.

In interpreting these data it is important to remember that the estimates of current service utilization do not distinguish between what the literature refers to as “contact coverage” versus “treatment or “effective coverage”. In other words, many people can be in contact with service providers but not be engaged in effective treatment and recovery support services. Our estimate here is essentially contact coverage since we have included, for example, ED visits mobile or walk-in/on call crisis, and triage and centralized assessment without necessarily knowing if these same people went on to engage in more focused treatment and support. Certainly, the qualitative feedback and the wait time data suggest challenges accessing not only front-end assessment but also concrete therapeutic interventions. Note too that we have not included the many contacts for assistance through helplines and crisis call centres, information-only contacts for example to AFM, MDAM or other self-help-organizations due to limitations in using those data. If these contacts were included our level of “contact coverage” would be even higher. Further to this line of thinking one reason the system coverage appears to be so much higher when mental health services are included is that there are so many more points of contact. Thus, **the higher contact coverage may not really reflect higher effective treatment coverage**.

Lastly, it should be noted that this approach to describing and assessing the overall coverage of treatment and support systems in Canada and elsewhere is relatively new^{107,108}. As such there are no guidelines available at present as to what might be an “adequate” level of coverage of the population need. As noted above one does not expect 100% coverage each year, since not everyone will seek help in the year; some people may receive one service but then transition to another in the year or perhaps at a future time, and some people will receive assistance and then be able to manage on their own for the foreseeable future. Coverage of the population in need is also driven by factors such as stigma and discrimination as well as pragmatic factors such as availability of transportation and weather conditions in rural and remote areas of Manitoba. This is, in fact, a complex modelling problem and the research is still evolving.

6.4 Summary of Current State: Integrating “What we Heard” with Quantitative Analysis

The Consultant Team took a very “deep dive” in the execution of a fulsome system review for the purposes of understanding and making recommendations for the improvement of access and coordination for Manitoba’s SUA/MH services. This included:

- An exhaustive document review
- A synthesis of needs-related data
- Collation of system-wide investment and budgetary information
- Quantitative analysis of on-line survey results with extremely high participation rates of services providers and the general public
- Detailed thematic analysis of qualitative information from the survey
- A similar qualitative analyses of information gleaned from site visits, one on one group or individual consultation interviews and two series of validation events
- A detailed data request leading to a synthesis of wait times, occupancy, ALC and service utilization data
- A modelling of system-level coverage of community need















In the presentation of the Strategic Plan itself ([Section 7.0](#)), including the identified Strategic Priorities, we will provide a narrative synthesis of the results and reasoning behind these Priorities and specific recommendations. To facilitate this synthesis, we have summarized

¹⁰⁷ Research is accumulating from other countries and jurisdictions that provide a rough basis for comparison with the Manitoba situation and yielding estimates that range from as low as 1% to 10% for contact coverage (Drummond, 2018). Differences in methodology still make the comparison to Manitoba quite tenuous

¹⁰⁸ See Nova Scotia Mental and Addictions System Review for a recent and parallel example for assessing SUA/MH coverage.

highlights and key findings in each section of the report as we have proceeded. To facilitate the final synthesis into the Strategy Priorities, we present a summary table, framed as “Gap Analysis”. Table 18A summarizes gaps across the many system support functions critical for an efficient, effective and equitable system of SUA/MH treatment and recovery support services. All supports are related directly or indirectly to access and coordination of services. Part B summarizes gaps in the functioning of the system, again, all related in some fashion, to improved access and coordination. Part C refers to specific gaps in the continuum of treatment and recovery supports, including specific challenges with transitions.

Table 18A. Gap Analysis Summary – System Supports

Themes/Gaps	Context	Current State Analysis			
	Document Review and Need Indicators	Online Survey (Quantitative)	Online Survey (Qualitative)	Consultation and Validation	Operating Characteristics and Coverage Estimates
More Prevention / Work on Social Determinants					
Limited application of population health approach / Disparity between need/complexity and investment and capacity					
No Provincial Planning / Too many silos / Enhanced governance					
Multi-sectoral coordination (e.g., MHSAL/RHAs and CFS)					




















































Jurisdictional issues/ support for Indigenous people/cultural aspects					
Impact of Children in Care / Res. Schools/trauma					
Provincial performance metrics and standards					
Unconnected/outdated information systems					
Evidence base of services/scale up of successes					
Adaptability and flexibility for evolving needs					
Education/preparedness of service providers					
Workforce Development including wellness, training, peer support, and some specific profession- based enhancements					

Table 18B. Gap Analysis Summary – General System Characteristics

Themes/Gaps	Context	Current State			
	Document Review and Need Indicators	Online Survey (Quantitative)	Online Survey (Qualitative)	Consultation and Validation	Operating Characteristics and Coverage Estimates
Inconsistent application of recovery orientation					
Inconsistent application of harm reduction – need for provincial coordination and plan					
Children and youth are at risk – more focus needed on treatment and early intervention					
Limited mental health and SUA collaboration and integration					
Room for improved collaboration with other sectors (e.g. primary care, hub models, services). Includes supports					

Themes/Gaps	Context	Current State			
	Document Review and Need Indicators	Online Survey (Quantitative)	Online Survey (Qualitative)	Consultation and Validation	Operating Characteristics and Coverage Estimates
needed for collaboration					
Limited services for family/loved ones					









































































Wait times too long (General)					
Inequitable distribution of resources					
Gaps in awareness of what's available/how to access					
Gaps in proximity of services to home					
Lack of flexibility to meet needs/ more choice					
Lack of cultural sensitivity/relevance					
Gaps in continuum/core services (general)					

Table 18C. Gap Analysis Summary – Specific Gaps in Services and Transitions

	Context	Current State			
Themes/Gaps	Document Review and Need Indicators	Online Survey (Quantitative)	Online Survey (Qualitative)	Consultation and Validation	Operating Characteristics and Coverage Estimates
Withdrawal Management (all levels)					
Residential services with more flexible options, including flexible length of stay, treatment approaches					
More ORT needed with psychosocial supports					
Shortage of forensic beds					
High Variability in Core Services					
Housing supports in community					
Transportation supports					

More reliable and rapid access to crisis response/ psych assessment. SUA/MH support in EDs					
More streamlined and rapid access to treatment					
Lack of navigation support for access or transitions- youth to adults, corrections to community, hospital to community					

6.4.1 Final Validation Events

The final series of validation events were held in February, 2018 and provided an opportunity for key stakeholders to review preliminary strategic priorities and recommendations. Since the content direction of the high-level priorities was generally consistent with the priorities identified in the initial validation events (e.g., population health planning, children and youth, Indigenous wellness, workforce) and still supported by subsequent qualitative data from the on-line survey and quantitative information from the data request that followed these events, there was very positive feedback about the emergent priorities and draft recommendations.

In preparation for these final validation events another graphic evolved that built upon the initial “pinball” graphic that summed up key elements of the overall “story” uncovered by the systems review and with respect to access and coordination. This summative analysis resonated

significantly with the participants of the final validation events and is replicated below in Figure 4.

On the left side of the diagram are the “drivers” behind the nature and extent of help-seeking for SUA/MH challenges in the province. These drivers are partly historical in nature, for example, long standing and cumulative challenges related to the social determinants of health, deinstitutionalization of mental health services, residential schools and other trauma, as well as challenges that are more current, including the increasing availability and diversification of psychoactive substances, long-standing and culturally ingrained alcohol use, the significant number of children in care, and the increasing acuity and complexity of people’s lives and related SUA/MH challenges. More recently, it is widely acknowledged that efforts to reduce stigma and discrimination related to SUA/MH challenges are gradually paying off and this is encouraging more people to seek help. Healing processes related to residential schools and the national inquiry into missing and murdered Indigenous women and girls have also prompted more people to seek help, although there is no doubt much more needs to be done.

While all these forces have been at play encouraging more help-seeking, the fiscal allocation for SUA/MH has stayed largely the same, with the majority of mental health budgets set during the deinstitutionalization process and the eventual creation of the RHAs. These resources were dedicated to the people with the most severe and persistent challenges while population needs grew significantly. This has no doubt added additional strain on both acute care and community-based services. SUA services have also not kept pace with demand, either in capacity or style of operating, and perhaps were not sufficiently resourced in the first place according to the level of community need. Development of early intervention and prevention services have also been held back, as illustrated by the limited analysis of system coverage.

Regardless of all the nuances of the complex system dynamics, an ever increasing number of people are seeking to access to services in a system that is essentially bounded in its resource capacity with investments that have been sufficiently planned from a systems point of view.

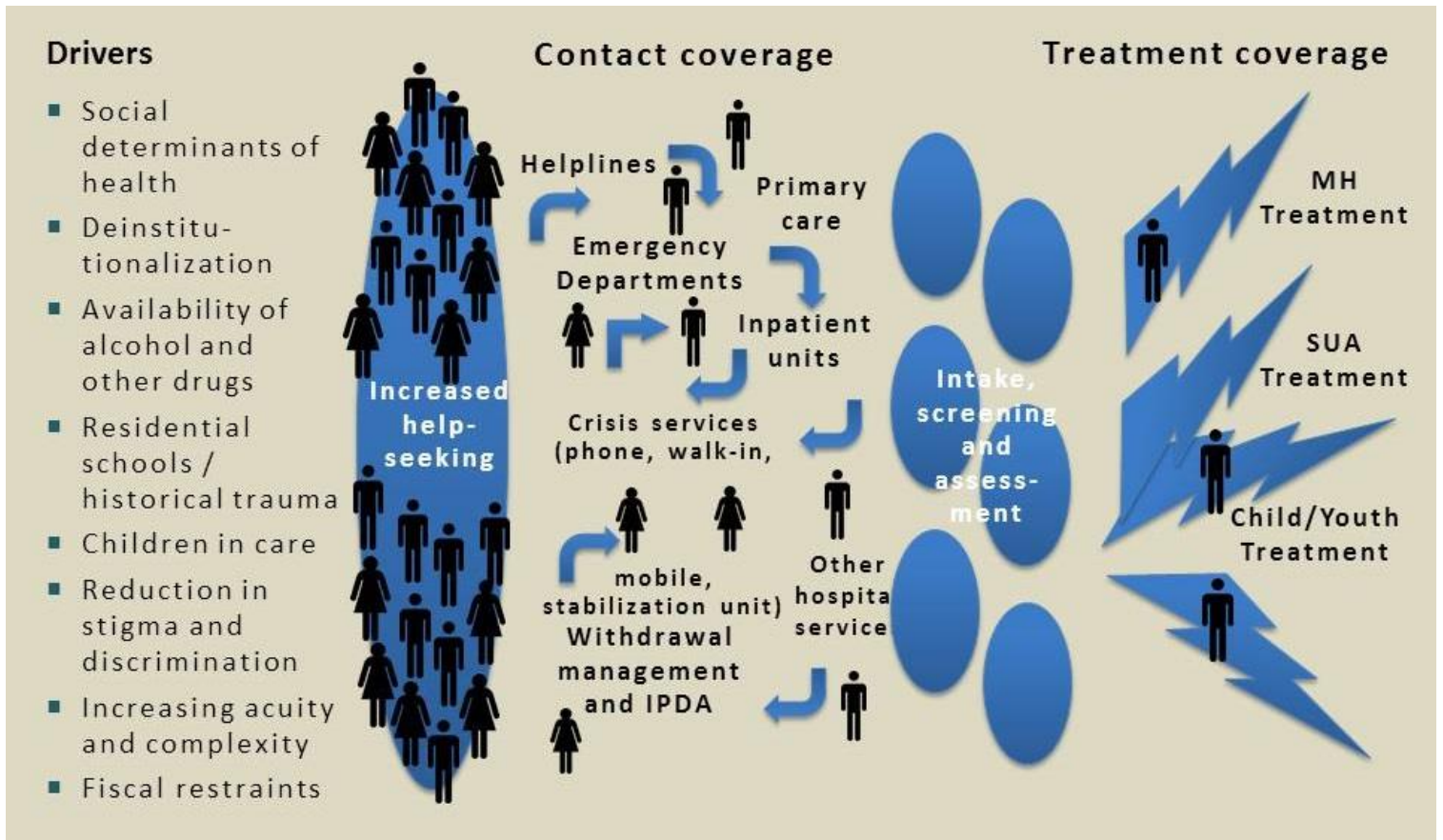
The middle part of the graphic demonstrates how the system has responded somewhat reflexively in order to increase access points within available resources and at multiple points in the system. This was illustrated previously in the “pin ball” graphic to reflect reports from people who encountered multiple filters and access conditions in a system that seems more inclined to ‘screen you out than welcome you’. Constraints on resources encourage that kind of organizational behavioural despite best efforts to collaborate. The structural, and to a very large extent, functional separation of the provincial SUA/MH services has further exacerbated this situation, especially given the high levels of co-occurring disorders. The graphic tells a story of people cycling through, and around, multiple points of contact but relatively few getting through all the filters in place to get to effective treatment or therapeutic recovery supports.

This part of the “story” resonated with information from virtually every source of information tapped for this review, including the final part of the picture which illustrates separate, and not very smooth, journeys through the poorly coordinated sub-systems – SUA, mental health and children and youth services. Admittedly, the depiction of these disjointed journeys is a gross over-simplification.

In summary, Figure 4 is the “story” that resonated so well with participants during the final validation events and which integrates the many themes and sub-themes pulled together in chart form in Tables 17A to 17C. The story is well supported by the many documents reviewed, including Manitoba-specific research, and was echoed throughout the on-line survey, consultations, discussions and validation events. The figure reflects the mix of factors which has created a kind of “perfect storm” for the challenges currently being experienced with respect to access and coordination of services.

The Strategic Plan, including its vision, goals, principles, strategic priorities, and specific recommendations, is intended to improve this situation for Manitobans by making concrete improvements to access and coordination of the province’s SUA/MH services. This will take a multi-pronged and sustained effort, given the complexity and seriousness of the situation and the length of time over which it has developed.

Figure 4. Conceptual framework illustrating the major challenges in access and coordination.



7.0 FUTURE STATE: Priority Areas and Recommendations

7.1 The ideal future State

In an earlier section of this report we articulated a set of characteristics or principles that help define a “well-functioning” treatment and recovery support system of SUA/MH services (see [Section 5.0](#)). The Consulting Team used a blended approach that identified key system features and principles with an eye to eventually articulating the broad vision of the Strategy, and related goals and principles. Three sets of principles or core system features were identified.

First, an ideal SUA/MH system must achieve a “good score” on indicators organized across the following 10 domains:

- **Acceptability** – services meet stakeholder expectations
- **Accessibility** – services are available at the right place and time
- **Appropriateness** – services are relevant to individual client needs and based on accepted standard
- **Anti-stigma** – policies, services and activities and attitudes do not label or stereotype a person by their illness or personal challenges
- **Competence** – provider knowledge and skills are appropriate to the service being delivered
- **Continuity** – services are coordinated across programs, practitioners, organizations and levels of care over time
- **Equity** – services do not vary in quality by client characteristics
- **Effectiveness** – services achieve desired results
- **Efficiency** – services achieve desired results with most cost-effective use of resources
- **Safety** – potential risks (to clients, providers and environment) are avoided or minimized

A second set of core system features or principles are articulated within VUCA, which is an acronym used to describe system or organizational capacity to respond to the **V**olatility, **U**ncertainty, **C**omplexity and **A**mbiguity of general conditions and situations. The concepts embedded in VUCA are particularly *apropos* to SUA/MH planning, and the Manitoba situation, given, for example, the emergent crystal methamphetamine crisis. On a very practical level, VUCA draws attention to the need for constant environmental awareness and readiness. .

Lastly, seven core principle of system design were identified and the links shown to issues related to access and coordination. A guiding principle of a “**systems approach based on population health**” considers the population in categories of need or severity and organizes the system to ensure an effective response for each sub-group, including prevention and early intervention and support for people with mild” or “moderate” levels of severity thus reducing incidence and alleviating the need for more costly services. The systems approach, grounded in the principles of recovery, encourages a “whole-of-government” and “whole-of society” response by enlisting broad support at multiple levels for access and facilitating coordination; highlights capacity for measuring return on investment.

A well-organized and functioning system also emphasizes **collaboration and partnership** so as to increase system capacity for access as well as service provision; improve navigation either through centralizing one-stop shops or well-articulated pathways and expands the overall reach of the system response.

It is critical that SUA/MH treatment and recovery services be **well-supported by a range of system supports**. This includes needs-based and other systematic planning processes which provide coverage targets by level of need in the population; information systems that inform client flow patterns and facilitates safe transitions across providers; performance metrics to identify hot spots and blockages in the system; workforce planning and development strategies to identify workforce competencies and diversity in relation to client characteristics and improve workforce health and recruitment/retention challenges that impact referral and coordination of care.

Especially important in the Manitoba context an effective treatment system **engages Indigenous communities**, including health professionals, in system planning, which helps break down jurisdictional barriers that impact both access and coordination; increases cultural competency of staff and cultural safety of clients that in turn encourages early help-seeking and reduces demand for the most intensive services.

Equally important is consideration of evidence and issues related to **developmental age, gender, equity and diversity** in designing effective treatment and recovery support systems so as to ensure a focus on the question: *Access for whom?* This encourages ongoing review of programs and policies that present population-specific barriers to access as well as challenges to continuity of treatment and support services based on disparity and inequity.

A **seamless continuum of services** ensures a stepped approach and identifies gaps in treatment and support pathways that challenge coordination; focuses attention on screening and assessment and matching people to the right level of treatment and support and reducing wait times. Lastly, within this continuum, the system includes close attention to the appropriateness and evidence underlying interventions, thereby improving outcomes, including recidivism and system flow. A client/family centred and trauma-informed approach is critical.

The findings from the various components of the system review, including the final validation events, resulted in the framework for Manitoba’s SUA/MH Strategy, presented in Figure 5 below. The framework is comprised of several parts: a **vision** for Manitoba, in regards to SUA/MH; a set of **principles** guiding the SUA/MH system; the **goals** to be achieved; the **strategic priorities** needed to deliver on those goals, and a set of **enabling supports** that, once built, will provide the foundation on which the SUA/MH system can deliver against its strategic priorities, goals, principles and vision.

7.2 Vision for Manitoba’s SUA/MH system

All strategies need to articulate the future state that the strategy is designed to achieve. Throughout the project’s comprehensive consultation process, Manitobans described the variety of ways that their vision for Manitoba’s SUA/MH system must be two-pronged - people have aspirations for (a) the mental health and well-being of Manitoba’s residents, and (b) the environments that exist to support people experiencing SUA/MH challenges. These two aspirations are captured in the vision statement below:

“All Manitobans enjoy the best possible
mental health and well-being throughout life,
and have welcoming, supportive and diverse communities
in which to live, participate, recover and heal
when facing mental health and substance use
or addiction challenges.”

This future state is the one against which the rest of the SUA/MH strategy is framed.

7.3 Principles for Manitoba’s SUA/MH system

The vision statement describes the future that Manitobans desire in regards to SUA/MH. People also talked a lot about the values and principles needed to govern the way this vision is achieved. These values and principles, listed below, were felt to be fundamental to guiding the way individual, organization and system-level decisions are made, and how transformation of the SUA/MH system should proceed.

- **Welcoming and respectful:** All Manitobans feel welcomed and respected *when seeking information, accessing or receiving SUA/MH services and follow up supports.*

This principle informs how the physical environments of services are designed, materials are developed, and people are greeted, engaged and treated throughout the service

delivery process. Application of this principle extends to the person seeking help, his or her family and friends, and other members of the person's treatment and support team.

Further, individuals' needs pertaining to age, gender, sexual orientation, physical, developmental, cognitive or medical challenges, language, culture, race, economic standing, education and/or past and present experiences, including trauma, are incorporated into overall system design and delivery of treatment and recovery supports. The SUA/MH system is inclusive, engaging and welcoming, rather than excluding and denying people access to services and supports due to their unique and/or complex situations and needs.

Finally, mutual trust, respect, honesty and openness will characterize the relationships and communication between the person, the person's family, and service providers.

- **Recovery-oriented:** *Manitoba's SUA/MH services and supports are delivered in a way that supports the recovery of the individual experiencing challenges.*

From the perspective of the individual with SUA/MH challenges, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, and development of personal autonomy, social identity, meaning and purpose in life and a positive sense of self.

Recovery-oriented SUA/MH services and supports are designed and delivered to recognize the uniqueness of each individual and to support and empower individuals to make their own choices about how to lead their lives. Recovery-oriented services support individuals to build on their strengths and provide real choices about how to do that. Such services also promote and protect an individual's legal, citizenship and human rights and instill hope in individuals about their future and ability to live meaningful lives. Recovery-oriented SUA/MH services acknowledge that each individual is an expert on his or her own life and that recovery involves working in partnership with individuals and their families to provide support in a way that makes sense for, and works for them. Continuous evaluation is enabled such that individuals and families can track their own progress. Individuals' experiences of treatment and support are used to inform quality improvement activities and the SUA/MH system reports on key outcomes that indicate recovery including housing, employment, education, social and family relationships, health and well-being.

Figure 5: Overview of Strategic Plan



- **Person- and family-centred:** *Individuals and families seeking assistance with SUA/MH challenges are considered and treated as equal partners in planning, developing and monitoring treatment and supports, to make sure it meets their needs. People and their families are at the centre of decisions and are seen as experts in their own lives, working alongside SUA/MH professionals and staff to get the best outcomes.*

Person- and family-centred treatment and support is not just about giving people whatever they want. It is about considering people's desires, values, family situations, social circumstances and lifestyles, seeing the person as an individual, and working together to develop appropriate solutions.

For a variety of reasons, however, people are too often expected to fit in with the routines and practices that health and social services feel are most appropriate. But to be person- and family-centred, services and supports need to change to be more flexible to meet people's needs in a manner that is best for them. This involves working with people and their families to find the best way to provide their treatment and support. This partnership can occur on a one-to-one basis, where individuals direct the decisions about their health and recovery, or on a collective basis, whereby people with lived experience are involved in decisions about the design and delivery of services. The underlying philosophy is the same: it is about doing things with people, rather than 'to' them.

- **Culturally relevant:** *SUA/MH services and supports are respectful of, and designed and delivered in ways relevant to, the health beliefs, health practices, culture and linguistic needs of Manitoba's diverse populations and communities, including Indigenous communities.*

The diversity of Manitoba's population continues to grow. Individuals and communities whose members identify as having particular cultural or linguistic affiliations, by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home, need to feel that the province's SUA/MH services and supports are designed and delivered in ways that meet their needs. This is a Strategy for all Manitobans.

Cultural relevance and responsiveness describes the capacity to respond to the healthcare issues of diverse communities, thus requiring knowledge and capacity at all levels: individual, program, organization and system. Different strategies are needed at each level to increase the cultural relevance of Manitoba's SUA/MH services and supports, for example: cross-cultural education and training that focuses on socioeconomic differences in access to supports related the determinants of health; communication skills; mechanisms for addressing experiences of racism and bias (individual level); changing program location, hours, service delivery approaches and materials to better meet the needs of different communities; inclusion of community members in the program's design and evaluation process (program level); reflection of racial and ethnic diversity in the organization's Board, leadership and workforce, through recruitment of staff from diverse communities (organization level); and creation of

cross-sectoral and cross-cultural forums to identify, discuss and address systemic barriers to access for members of diverse communities (system level).

Related to the concept of cultural relevance is the notion of cultural safety. Cultural safety articulates an approach to SUA/MH service planning, organization and delivery that supports an environment free of racism and discrimination where people feel safe receiving SUA/MH treatment and support. By reflecting on personal and systemic biases, a focus on cultural safety ensures that SUA/MH service delivery develops and maintains respectful relationships, based on humility and mutual trust

- **Harm reduction-focused:** *Manitoba's SUA/MH system embraces and delivers services and supports aimed at reducing the harms experienced by individuals, families and communities related to SUA/MH challenges.*

As part of its commitment to being a recovery-oriented system, Manitoba's SUA/MH system will also be a harm-reducing system. Harm reduction and a recovery orientation are entirely consistent principles in a system in which services and supports are designed and delivered to recognize the uniqueness of each individual and support and empower individuals to make their own choices about how to lead their lives.

Harm reduction constitutes a fundamental strategy in contemporary SUA/MH treatment and benefits not only the person experiencing MH/SU challenges, but also their family and the community. Harm reduction in this context is defined as the combination of policies, programs, pragmatic practices, and practical goals that aim primarily to reduce the adverse health, social, and economic consequences of the legal and illegal use of psychoactive substances, without necessarily reducing substance consumption. Harm reduction in the contemporary context also focuses on underlying causal factors such as inter-generational trauma. Harm reduction is complementary to prevention and treatment approaches, and empowers substance users to make informed decisions, even with respect to policy-making and program development. It focuses on users' access to the highest attainable standard of health care and social services, and is evidence-based and cost-effective, addressing health and social harms associated with legal and illegal substance use, such as soft-tissue infections, blood borne diseases, overdoses, violence, criminalization, and stigma.

- **Evidence-informed:** *Decision-making about Manitoba's SUA/MH policy, planning, and service and support delivery is evidence-informed—that is, decision-making is based on what is known about what works to support the mental well-being of all Manitobans, and the recovery of those experiencing SUA/MH challenges.*

Evidence-informed practice and decision-making involves using various types of research and information when making decisions about SUA/MH policy and practice, including consideration of the best available research evidence, individual client preferences and values, the clinical state and circumstances, and practitioner knowledge and experience. It allows creativity and

innovation in SUA/MH policy-making and practice by underpinning SUA/MH practice and decision-making with sound theory and methodology while at the same time being flexible and responsive to different individuals, groups and/or communities. Evidence-informed practice and decision-making actively promotes the belief that different “ways of knowing” contribute to alternative sources of valuable information for improving SUA/MH policy and practice.

Evidence-based practice within the SUA/MH system should: be used to plan and implement actions that result in effective short- and long-term outcomes; take into account the capacity of the individual, program, organization or community under consideration; be sensitive to the specific context in which the SUA/MH issue occurs (i.e., setting, culture, history and available resources); recognize that moral, ethical, cultural and spiritual values affect what we are prepared to do and not do to improve health, as a person with lived experience and/or practitioner; use the best data available from reliable and high quality sources; and be applied in a systematic way to enable appropriate evaluation approaches.

- **Trauma-informed:** *Manitobans are able to access SUA/MH services and supports that recognize the impact of trauma on one’s mental health and well-being, create environments and a system where the potential for further (or re-) traumatization is mitigated, and enable those accessing the services and supports to learn and grow at a pace that feels safe.*

As defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), a program, organization or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in individuals, families, staff and others involved with the service or system; responds by fully integrating knowledge about trauma into policies, procedures and practices; and seeks to actively resist re-traumatization.

Trauma-informed practice recognizes the experiences of trauma arising from childhood abuse, neglect and witnessing violence, as well as other traumatic life events that are out of one’s control. Trauma-informed practice is not necessarily about treating and healing experiences of trauma. Rather, it focuses on creating environments where the potential for further traumatization or re-traumatization (from events that reflect earlier experiences of powerlessness and loss of control) is mitigated, and where the individual accessing services can learn and grow at a pace that feels safe. Trauma-informed practice is closely related to culturally safe practice, both of which are essential to best support people’s recovery from SUA/MH challenges.

- **High quality and innovative:** *Manitoba’s SUA/MH system invests in, and leverages, evaluation and research to identify and disseminate which services work for whom and in what contexts, uses research methods appropriate to the full range of services and supports studied, and stimulates and supports innovation on what best promotes mental well-being and supports people’s recovery from SUA/MH challenges across the system.*

High quality and innovative SUA/MH services and supports are provided in the context of, and responsive to, people's economic, cultural and social situations, are based on the latest relevant knowledge, and are oriented toward successful coping, empowerment, self-direction and recovery. Such systems invest the time and resources needed to study and translate research and evaluation studies to identify, implement, and make accessible what works in a transformed SUA/MH system. The research methods used within the system (e.g., ranging from randomized controlled trials to participatory action-based research) adhere to the system's values and are appropriate to the wide range of SUA/MH services and supports studied. The system stimulates and supports innovation on how best to promote mental health well-being and support people's recovery, no matter where this innovation comes from (e.g., large hospital, small community organization, peer support network, Indigenous communities). Such a system also invests in the ongoing training and education of its workforce to sustain the delivery of high quality, outcome-achieving services and supports across the system.

- **Accountable:** *Individuals, families, SUA/MH service providers, programs, the SUA/MH system and the wider community are all accountable for the mental health and well-being of Manitoba's residents – everyone owns a share.*

Individuals, family members, SUA/MH service and support providers, other health and social service providers, funders, and communities must collaborate and hold each other accountable across geographies, sectors and systems to meet the needs of individuals and families experiencing SUA/MH challenges. The objectives of a transformed SUA/MH system cannot be achieved if:

- individual providers deliver their services and supports to individuals or family members in isolation of what others are doing
- community agencies and hospitals work in isolation of others and exclude people from their services because of their complexity of needs
- the system reinforces fragmentation and service and support silos through historical funding practices and the use of outdated outcome measures
- communities believe that they bear no responsibility for supporting the recovery of people experiencing SUA/MH challenges.

Rather, individuals, families, SUA/MH service providers, and other health and social service providers must work together across sectors and systems to improve the mental health and well-being of all Manitobans. Community agencies and hospitals must work in partnership with others to welcome people into the SUA/MH system and to support people to implement their own recovery plans. The system must be flexible to respond to people's changing needs and to be held accountable for the individual and family-defined outcomes it achieves. Community members must be educated and engaged with people experiencing SUA/MH challenges so that they understand and feel equipped to play a supportive role.

The accountable SUA/MH system achieves individual- and family-defined outcomes with the most cost-effective use of resources and a clear framework exists to ensure effective monitoring and management of SUA/MH system performance. SUA/MH service providers are also each accountable, individually and collectively as teams, for identifying quality improvement opportunities, initiating self-learning, and persevering to improve Manitobans' mental health and well-being.

Manitobans also told us that while identifying and articulating the above set of principles is fundamental to the achievement of SUA/MH system transformation, even more important is broad communication of, adherence to, and alignment with government, organization, program, service provider and individual decision-making, action and practices in support of these principles, throughout the transformation process.

7.4 Strategic priorities for Manitoba's SUA/MH system

In order to achieve the vision for the mental health and well-being of Manitobans, to adhere to and embody the identified principles, and to meet Manitoba's SUA/MH access and coordination-related goals, all stakeholders—including individuals, families, SUA/MH service providers, other related service delivery sectors, provincial government departments, and other levels of government (i.e. federal, First Nations, Metis, etc.)—must work together and organize their efforts to deliver against the six (6) strategic priorities outlined below.

1.0 Population health-based planning, disparity reduction and diversity response

There was almost universal support for more provincial-level planning, based on a population health perspective that addresses the full range of needs among community members, and distributes resources across the province in a fair manner, according to need and unique regional circumstances. This was seen as key to not only ensuring equitable access to treatment services and recovery supports, but also reinforces the need for a complementary effort focused on prevention and health promotion. A public health, population-based approach is consistent with the current advice of experts affiliated with the World Health Organization's¹⁰⁹ approach to prevention and treatment of SUA/MH challenges. It allows for focused attention on health service delivery while at the same time incorporating strategies to get at root causes, which in the end, also reduces the demand on the health care system and improves access for those who need assistance.

¹⁰⁹ Barry, M., Clarke, A. M., & Petersen, I. (2015) Promotion of mental health and prevention of mental disorders: priorities for implementation. *Eastern Mediterranean Health Journal*, 21 (7), 503-511.

The “tiered framework” also resonated with stakeholders in the consultations and validation events. It was familiar to many participants, making it a comfortable fit as an organizing framework and planning tool for the new Strategy. The fact that the tiered framework also draws attention to the need for complementary prevention and health promotion activities, including those focused on the social determinants of health, was also a selling feature. Importantly, an opportunity to focus on the social determinants was not only about prevention and reducing incidence of SUA/MH, but also linked to the theme, repeated throughout the system review, that equitable access to services, and effective transitions between them when needed, was closely related to factors such as the availability of housing, transportation and basic income. Many practical examples of barriers were provided, including needing money for a doctor’s medical note, dispensing fees for medication, bus or taxi fare or child care, so that appointments can be kept. These dimensions of access are not about filling “gaps in the treatment continuum” as much as they are about ensuring people have fair and equitable access to the services that are available.

One of the most important implications of a public health/population health approach to planning is the need for a “whole system/multi-sectoral” response— or what experts are now calling a “whole-of-government and whole-of-society” response to SUA/MH. This plays itself out in many important ways, including an understanding that virtually all government programs and policies have a role to play in contributing to health, in this case, a broad interpretation of mental wellness. The broad multi-sectoral response is also critical for enhancing partnerships that significantly extend the reach and effectiveness of the specialized SUA/MH services and supports, which, on their own, cannot meet the full spectrum of community need. For example, support is needed from sectors such as hospitals (EDs, acute care), and community-based services to ensure a stepped treatment and support system is in place, to support people in crisis related to opioid overdose or a crystal methamphetamine-related psychotic episode. Stakeholders cited many such examples of a stepped approach that facilitates access and coordination of services. Multi-sectoral support is also needed between sectors such as Primary Care, Education and Training, and Child and Family Services, to ensure the large population of people with “Tier 2- level” SUA/MH challenges have access to early identification and early intervention services. While there are many evidence-based approaches to the provision of such services for adults (e.g., screening and brief intervention in primary care), this also calls for coordination of efforts, streamlining messaging and reducing duplication in critically important settings, such as primary and secondary school settings.

Research is now conclusively in support of the business case for investing in SUA/MH services and supports. The “whole-of-government” and “whole-of-society” approach means that everyone needs to own their share so everyone can benefit from the societal “profits”. This will call on MSHAL to take a leadership role and enlist the support of their government colleagues,

as well as a host of important non-governmental stakeholders, including the private sector, in achieving the promise of this new approach for Manitobans.

This Strategy sets a way forward for the more detailed planning and operationalization of the recommendations contained within, with the tiered model being a useful tool in this process. That being said, research also reminds us that health systems, including systems of services for SUA/MH challenges, are “complex adaptive systems” that are constantly in flux and often in unpredictable ways. This means that a population-health approach must also ensure flexibility, surveillance and the availability of structures and processes for rapid response to emerging challenges, such as new trends in drug use or extreme weather conditions such as flooding that require migration of whole communities for extended periods of time and result in the need to support people in these times of stress and trauma.

Another aspect of this population-based approach is the need to recognize and respond to the full scope of harms related to different psychoactive substances. This requires retaining a strong focus on alcohol use and abuse while also managing current crises related to prescription opioid use and crystal methamphetamine. This can be challenging in the face of the very tragic circumstances associated with these substances. A public health approach, therefore, needs to be both sensitive and responsive to these tragedies, while also retaining its focus on those substances that result in the most significant societal harms. Based on national and Manitoba-specific data, alcohol wins hands down, pointing to the significant and ongoing need for alcohol prevention, early intervention and treatment. The same can perhaps be said about the high prevalence of depression and anxiety disorders and both completed and attempted suicide. These also call for a broad-based public health approach.

Respect and support for diversity is a core aspect of the Vision and the key principles for the Strategy identified above, and must be reflected in the operationalization of a population-based approach to planning. This approach must speak to the needs of all Manitobans, including its Indigenous people, and must be sensitive to gender, language, colour, race and religious beliefs. The core Strategic Priority related specifically to Indigenous people (see [section 5.0](#)) goes into more depth in this area and is heavily focused on the healing of historical and current trauma. However, in light of the recent welcoming of so many newcomers and refugees, respect and support for diversity must also translate into proactive supports to assist these new Manitobans with their difficult transition; difficulties which are often exacerbated by the effects of trauma experienced during their personal journeys and which we learned continues in many respects upon their arrival to Manitoba (e.g., lack of trust in government institutions, lack of employment opportunities, challenges understanding different ways of parenting, accessing services in another language). A key learning from consultation with these new Manitobans was the need for access to services that are sensitive to and delivered by service providers familiar

with their cultural backgrounds. There are also many other aspects to diversity that need to be embodied in a population-health approach, including issues related to gender-identity and sexual orientation, that we heard impact the extent to which individuals experience services as welcoming and respectful and physically and psychologically safe.

Recommendations:

- 1.1 Ensure a “whole-of-government” and “whole-of society” approach to the implementation of this Strategy for enhanced access and coordination of services, including a complementary focus on the overall determinants of health in Manitoba so as to reduce the need to access services as well improve the coordination and effectiveness of existing services.
- 1.2 Base the implementation of this Strategy, as well as future provincial planning, including more detailed provincial clinical and preventive service planning, on the tiered framework as well as on population trends and key health indicators, with due consideration for regional and community context.
 - Use the tiered framework developed in this report as an organizing guide with core services and supports aligned with level of need and complexity in a stepped model of treatment and recovery support services.
 - Develop adaptations of the tiered framework for work with children and youth as well as a more Indigenous-based model that is more strength-based and representative of the scope of community needs and appropriate responses.
- 1.3 Create a formal health response structure to manage emerging SUA/MH challenges, such as the opioid overdose crisis or the current crystal methamphetamine situation, and community issues that have an impact on SUA/MH, such as extreme weather conditions that require displacement of whole communities for extended periods of time. This rapid response system should be flexible and should include cross-sectoral surveillance systems.
- 1.4 Consistent with the recommendation of the Peachey report, allocate 8% of SUA/MH resources for prevention, recognizing the close relationship between responding with early intervention services to emerging SUA/MH challenges and the need for subsequent services in the future.
- 1.5 Reinforce alcohol prevention and risk reduction as a critical aspect of the overall provincial strategy for improving access and coordination. While there is a critical need for focused substance-specific work, such as for prescription opioids, crystal methamphetamine and cannabis, it is essential to retain a strong and consistent focus on alcohol given its burden on Manitoban society, including cost to the health care and other sectors.
 - Consistent with the main body of this recommendation expand access through the provincial drug formulary to naltrexone, including injectable naltrexone, and

acomprostate, two evidence-based medications for the treatment of alcohol use disorder.

- 1.6 Develop a coordinated provincial program for the prevention of suicide among adults and children and youth, including the development of options to intervene with treatment, thereby preventing the tragic loss of life through a more effective response to suicide attempts.

Disparity reduction and diversity response

- 1.7 Develop and implement system-wide strategies to increase the identification of SUA/MH-related health disparities
 - Develop of, and make maximum use of existing, surveillance systems, including harmonizing service delivery information systems, to monitor disparities between need and actual access to services.
 - Ensuring maximum synergy with Federal/Provincial data systems.
 - Respect the importance of data collection, analyses, and storage in the context of Indigenous communities and governance structures.
- 1.8 Implement a common perception-of-care questionnaire across SUA/MH services providers to allow for routine feedback and analyses in relation to key equity/demographic characteristics of people using services. This can be implemented on a common web-based platform as In Ontario.
- 1.9 Increase representation, on organizational boards and advisory committees, of marginalized groups, including people from indigenous backgrounds, newcomers and refugees, people of different sexual orientation and gender as well as youth. For example, include a youth from the newcomer/refugee community on the NorWest Youth Advisory Committee.
- 1.10 Develop and implement system- and organization-wide strategies to address identified high-priority SUA/MH-related access and health disparities as listed below in recommendations 1.11 to 1.15.
- 1.11 Ensure a developmental age perspective in the delivery of SUA/MH services and, to the extent possible, remove barriers to access and coordination that are based solely on the age from birth date.
- 1.12 Ensure surveillance of, and sensitivity to, gender-based inequities, particularly those experienced by women and girls – e.g., victimization and domestic violence, income disparities that affect access to care, and issues related to maternal health and parenting, including challenges associated with losing and regaining custody of children in care.

- 1.13 Review the policies and operational procedures of residential and inpatient services, including withdrawal management services, to ensure the physical and psychological safety of people who identify with the LGBTQQ community, as well as provide opportunities for choice. Particular effort is needed to support those who are transgender or are in transition.
- 1.14 Recognize and work to reduce the effects of income disparity among the large majority of people needing access to SUA/MH service. Examples include potential waivers of dispensing fees for required medication, and subsidies to cover costs associated with medical and/or psychiatric assessment, transportation and child care required for service participation.
- 1.15 Establish a Provincial Task Force to investigate options for transportation, focused on the experiences and best practices in other jurisdictions (e.g., BC and Ontario), with due consideration for cost and safety considerations

2.0 Comprehensive continuum of evidence-informed services and support

In this Strategic Priority, we consider the gaps in the treatment and support system that are challenging Manitoban's access to effective services and supports. The next Strategic Priority is concerned with enhancements to the *integration* of these services and supports, as well as the coordination with other systems and sectors.

It is not possible to consider gaps in the service continuum without reflecting on the considerable regional, and often population-specific, variation in the services that are currently available to Manitobans. The over-riding pattern of results, including the analysis of previous planning exercises, the mapping of current services against an "ideal" continuum of treatment and recovery supports, qualitative feedback and quantitative data, was largely one of *inequitable access*. The "story" told in Figure 5, about the factors underlying the evolution of the system towards its current state, is largely a story of unplanned development, taking advantage of any new funding that does arise to try and fill a "gap". While this may have been a solution to one problem, the lesson learned from complex adaptive systems is that you often create one or several other unanticipated problems. A case in point might be the development of the CRC in Winnipeg to relieve pressure on the city's emergency departments, which resulted in the addition of another entry point with a concomitant increase in help-seeking and more challenges getting people to actual treatment.

To the extent that this Strategy will lead to a comprehensive, operational, preventive and clinical services plan – a truly provincial plan—the first lesson from this history is to stop plugging perceived gaps in the system until that plan is in place. The role of the Strategy then is to provide guidance for planning with suggested short and longer-term priorities. Beyond

designing a new provincial system before resourcing significant new services, our first advice is to be very cautious about building new entry points into the system, or making major modifications to current processes, without ensuring pathways are in place for effective treatment and recovery services and supports. Secondly, and using the tiered framework as a guide, careful attention is needed to enhance these services and supports across all tiers of severity and complexity. This can be a significant challenge as those in Tiers four and five often present for help with urgent, often life threatening, needs, and Tier five often draws public and media attention and demand for solutions that are implemented too quickly because “something has to be done”.

Related to the general issue of equitable access, the “gaps” in the current continuum of services are not always a matter of an evidence-based service not existing at all, although there are some examples of this (e.g., screening and brief intervention for at-risk alcohol use; mobile, community based WMS), but rather the more common situation observed was that a gap exists but as a matter of “degree”. There are several versions of this situation:

- the service exists but there is not sufficient capacity, or it exists in some regions but not others (e.g., community mental health teams, including the number of PACT teams; full regional coverage for mobile crisis or youth crisis; more services for acute intoxication, medication management for alcohol craving; SUA treatment for women; insufficient ORT services);
- what exists may need to be modified (e.g., more up-to-date youth treatment models, longer residential SUA treatment; adapted treatment models to maximize occupancy; increased security to facilitate acceptance of people into existing inpatient mental health beds; expanding admission criteria (e.g., expanded access to medical detox in the HSC beyond alcohol and opioids)); or
- what exists may not really be needed or lacks an evidence base (e.g., residential treatment for problem gambling; extended use of acupuncture for addiction treatment).

An important implication is that a traditional approach to a “gap analysis”—that is, a gap is identified, the evidence is reviewed and weighed about filling that gap, and a recommendation for implementation ensues—is too simplistic a scenario for the present system review and Strategic planning exercise. While there are some significant gaps that can benefit from such a linear evidence-based approach—for example with respect to the need for mobile community-based withdrawal management and screening and brief intervention for at risk alcohol use or depressive disorders—a different approach is needed for most of the recommendations that follow. In some cases, a recommended increase in existing service capacity—for example, extending regional coverage of mobile crisis, addition of PACT teams or increased forensic beds—does not need a major evidence review as it is an extension of a core service few would argue with and is already well-considered by local planners and or previous expert reviews as a

need based on service demand. In other instances, a complementary system enhancement is also required, such as for medical or non-medical withdrawal management services, both of which are evidence-based practices, to increase capacity for residential stabilization services to facilitate subsequent treatment entry without first requiring a return to home or to the street. This staged approach is an emerging best practice shown to be successful (data not yet published) in Fraser Valley, BC, in reducing ED visits. In some cases, we recommend additional review and planning to see if the existing services can be adapted without a major increase in resources; for example, more flexible lengths of stay in residential SUA facilities to facilitate longer treatment when needed.

In the end, the recommendations for gaps in the system are a “gestalt” of all these factors, drawing on high quality research where possible; the experience of the Consulting Team and their professional national and international networks and; what we consider to be the informed opinion of system stakeholders that have already developed well thought out proposals for system enhancement and which the Consultant team has reviewed so as to assess consistency with our findings and the overall Strategy.

Despite the challenges identified in measuring overall treatment coverage, it is apparent that the level of coverage is particularly low in the case of SUA services, compared to mental health services. This substantiates an important conclusion drawn in the Peachey report that in this sector specifically, there is a significant gap between the need and requests for service and the capacity of the system to respond. In addition, the largest percentage of individuals in need for SUA as well as mental health services and supports are being seen by physicians, hospitals and EDs. This highlights the need for collaborative service arrangements and ensuring adequate support is available to the health care professionals working in these busy, and often stressful, settings. This finding also connects to a major theme in the qualitative data, namely the stigma and discrimination commonly experienced by people accessing hospital-based services, in particular the ED; again, highlighting the need for improved on-the-spot capacity to respond.

One of the recommendations of the Peachey report was for the designation and creation of several mental health hubs outside of the WRHA, a recommendation based on very thoughtful analysis and deliberations completed as far back as 2013 by senior provincial mental health leadership. This recommendation is strongly supported by the Consultant Team as a means of establishing several core services required to respond effectively to the most immediate crises, and to bolster the capacity in the ED setting to support people with SUA/MH challenges, including through access to psychiatric assessment and linkage to community-based services as appropriate. Currently there is too much variability in the response to ED presentations for SUA/MH across the province due to inequitable gaps in access to psychiatric services as well as the local continuum and service delivery capacity. The ED Wait Times report highlighted the

need for more mobile/virtual access to psychiatric consultation to rural/northern EDs by psychiatrists in Winnipeg and other larger sites which are 24/7 supported. Support is also needed to RCMP officers so they know they do not have to transport people in need of these services, potentially long distances. Being transported, or sitting waiting in the ED in the charge of the RCMP, is also stigmatizing for patients. However, so as avoid confusion with other hub models” recommended in this report, such as the “youth hub” model and “community mobilization hubs”, we feel it is important to brand and develop these as regional “**focal points**” rather than “hubs”. These hub models also need to have capacity for supporting people with either primary SUA challenges or co-occurring disorders as a standard of service. They also must have adequate infrastructure for ensuring the safety of staff and patients, including on-site or on-call security services.

In the case of enhanced supports for family members, we heard consistently that this core service, available within a broader recovery-oriented system, requires both direct services and supports to family members, as well as enhanced communication about the services their family member or loved one is receiving. This is a challenging area for system enhancement, for example, due to privacy concerns, but one which has been successfully taken on by at least one other Canadian jurisdiction with a concerted provincial effort (Nova Scotia). Given the extent to which it was voiced as an area requiring considerable work in Manitoba, we have recommended a provincial initiative be put in place and to look to the Nova Scotia experience for some guidance, lessons learned and resource materials.

Recommendations:

To facilitate consideration of a rather lengthy list of recommendations, provided through a stepped treatment and recovery support lens, as well as subsequent discussion about short-term versus more medium- or longer-term priorities (see section below on [short-term priorities](#)), we have clustered sub-domains under this Strategic Priority in the following three sub-categories:

- ***Enhanced SUA/MH information, referral and navigation supports***
- ***Enhanced SUA/MH entry level services and supports***
- ***Enhanced SUA/MH treatment and recovery supports***

Enhanced SUA/MH information, referral and navigation supports

In the context of a detailed, provincial preventive and clinical services plan to be developed for SUA/MH in Manitoba:

- 2.1 Develop and implement a SUA/MH literacy program to educate the general public and key stakeholders—such as employees of other government departments, including

Families, Justice and Education and Training, employers, insurance companies, police services, educators, and members of legal professions—about SUA/MH challenges and how the Manitoba system is organized to respond to the needs of community members.

- 2.2 Ensure that each RHA provides clear information about the SUA/MH services they offer and how to navigate them through their respective websites and other proportional and information materials
- 2.3 Expand and accelerate services and supports to family members and other loved ones including increased support for family navigator services.
- 2.4 Design and implement a provincial program for facilitating consent to share information with family members and other loved ones, including education and training of SUA/MH workers to allay fears about PHIA. This work should be informed by lessons learned in Nova Scotia, where a similar provincial initiative has been undertaken, from which guidance and resources may be available.

Enhanced SUA/MH entry-level services and supports

- 2.5 Ensure that pathways to concrete and evidence-based *therapeutic* services and supports are defined and agreed upon prior to any plans that focus solely or primarily on increasing access to services.
- 2.6 Increase capacity for all levels of withdrawal management, including community/mobile, social, and medical, with flexible lengths of stay to facilitate transitions to crisis stabilization and/or directly to treatment.
- 2.7 Provide a (shared) full-time nurse practitioner in both Main Street Project (men's) and River Point (women's) WMS to streamline medical clearance required for service entry and to support any medical oversight required by clients.
- 2.8 Increase capacity for short-term stabilization, both medical and non-medical, with flexible lengths of stay so as to facilitate transitions to treatment, including stabilization services for people in crisis due to crystal methamphetamine use.
- 2.9 Expand focus of medical detox at the HSC beyond its current exclusive emphasis on alcohol and opioids.
- 2.10 Co-locate peer support workers in the Crisis Response Centre in Winnipeg, pending clarification of the capacity of this initiative for the provision of peer support with respect to SUA and co-occurring disorders.
- 2.11 In the RHAs other than the WRHA, operationalize the provincial mental health hub model identified in the Peachey report, with a view to: (a) branding and developing these as **integrated regional mental health and SUA "focal points"**, using the term "regional focal point" so as to avoid confusion with other hub models referenced in the Strategy, and (b)

harmonizing a core set of regional services and supports to the EDs and crisis services in identified regional locations. Core services in the “regional focal point” should include:

- Capacity for SUA and co-occurring disorders support, including screening and assessment
- 24/7 access to psychiatric consultation and acute assessment/treatment services
- A core set of professionals in addition to psychiatrists – e.g., Clinical Psychologists and Psychiatric Emergency Nurses (PENs) These professionals should also have capacity to support people with primary SUA challenges.
- Cross-trained mental health and addiction liaison workers co-located in EDs and other hospital programs and affiliated with a nearby integrated community team as a core service of the model, in lieu of cross-trained PENs, if PENs are not available.
- Infrastructure and staffing (i.e., facility suitability) to ensure safety and security of patients and staff.
- Linkage to community mental health and addictions services, including centralized intake.

Enhanced SUA/MH Treatment and Recovery Supports

- 2.12 Increase capacity for community-based treatment services, including extended hours of operation; more flexible and streamlined intake and assessment processes, including group intake and walk-in organized to fill no-show appointments; expanded community outreach services; promotion and support for the use of self-management tools; and intensive day and evening programs.
- 2.13 Expand telehealth-delivered SUA/MH services to rural and remote communities, with a focus on **adults** to complement the service under development for youth by the MATC.
- 2.14 Increase capacity for SUA/MH oriented supported housing options, including a harm reduction home in Winnipeg.
- 2.15 Increase capacity for residential SUA treatment with a focus on: significantly enhancing capacity for women and youth; increasing flexibility concerning the 72-hour period of abstinence prior to admission; lengthening treatment programs, including flexible program duration based on individual need; and adding wait-list supports as well as post-treatment continuing services.
- 2.16 Develop medical/psychiatric inpatient services at SMHC with a provincial mandate for treatment of people with complex co-occurring disorders. Also expand services at SMHC to include outpatient psychiatry to facilitate community access to psychiatry and support discharge to community.

- 2.17 Increase capacity for ORT, with a focus on more rapid access to specialized ORT services (e.g., RAAM clinics) and transition to primary care when stabilized and for on-going support; and ensuring linkage to psychosocial supports and counselling on the basis of individual needs.
- 2.18 Increase capacity for harm reduction services, including the creation of a provincial program for needle exchange; and a better coordinated provincial Naloxone distribution program.
- 2.19 Accelerate support for an additional PACT team in the WRHA. Based on evidence, a jurisdiction should have a PACT team per 100,000 population. With this, Winnipeg requires 3 – 4 more teams, beyond the current 3 teams.
- 2.20 Increase overall capacity for community- based mental health services, for example, to relieve pressure from inpatient psychiatry, including SMHC, and to assist with step-down from PACT.
- 2.21 Increase the number of provincial forensic beds and accelerate the process of coordinating transitions between forensics services at SMHC and PX3 in the HSC, and from correctional facilities.
- 2.22 Increase capacity for EPPIS outside the WRHA, focusing first on PMH.
- 2.23 Increase capacity within the full continuum of mental health housing supports, especially for people with complex needs and transition housing to support women seeking to regain child custody following treatment.
- 2.24 Define and, where possible, harmonize the proctor/support worker role in RHA-based mental health services, recovery coaches in SUA services, and certified peer support workers, and explore a formal mandate within these roles to provide transportation supports to facilitate both access to, and transition across, services and supports.
- 2.25 Enhance and accelerate community-based SUA/MH services and supports for newcomers and refugees, with a focus on trauma-focused interventions delivered through appropriate community-based organizations; support to the whole family; and ensuring integrated capacity for SUA.
- 2.26 Enhance and accelerate support for people experiencing sexual and other significant trauma, including, but not limited to, childhood physical and sexual abuse, victimization, and residential school/historical trauma.

- 2.27 Enhance and accelerate evidence-based treatment services including:
- Services for people with eating disorders, including residential services
 - DBT-based services for people with personality disorders
 - Anti-craving medication for alcohol use disorders
- 2.28 Accelerate the process of providing security services to Eden Mental Health Centre and incorporate these services and other resource and planning considerations into further role clarification of this facility as a provincial resource.

3.0 Seamless delivery of integrated services across sectors, systems and the life span

In addition to the specific gaps or challenges within the service continuum addressed by the recommendations in the preceding section, a resounding theme emerged from the various sources of input into this system review concerning poor coordination of services and the need for more integrated treatment and recovery support. This certainly validated the choice of service coordination as one of the two major themes. As the system review proceeded, coordination challenges became evident with respect to:

- The continuum of SUA services
- The continuum of mental health services
- The connectivity between SUA and MH services
- The connectivity between SUA and MH services with other sectors, including other parts of the broader health system

Reflecting again on the overall “story” behind the current SUA/MH system, there will be no easy fix to the many challenges identified in each of these four areas. The “rules of engagement” that have been established to restrict admission to services, rather than provide a welcoming doorway into treatment and recovery supports, are firmly entrenched in the system at multiple levels. These “rules” of the pinball game will not be so easily undone.

In some cases, it will be a matter of adding transition supports, such as navigator assistance or wrap-around services or, as noted above, more stabilization supports between WMS and SUA treatment. The same is true for the call from stakeholders for post-treatment transitions to ongoing recovery supports. Another example is transition supports needed to support people coming out of correctional facilities, for example, support for accessing primary health care, housing, additional SUA services and/or required medication for a SUA/MH illness. Support to youth who are transitioning to young adulthood and adult services is still another example that was voiced repeatedly and is well-supported by various evidence-based models and experience in Manitoba and elsewhere (see [Strategic Priority 4.0 for Children and Youth](#)).

In other instances, what is needed is a significant investment in different models of community housing, including supported housing, more independent living options, and personal care homes, for example, to help people transition out of SMHC and inpatient psychiatry units to more appropriate, and certainly more cost-effective, residential care and housing with support options.

In other instances, what will be required is a significant culture-shift. One key example is the need to address long-standing issues related to the structural and functional separation of SUA and MH services. This separation is so deeply engrained in the province's history of SUA/MH services that it has affected not only the nature and continuity of treatment and support available to Manitobans, but also the provincial capacity for research, planning and development of new services. Examples include the need for closer engagement of SUA services in MyHTs, provincial peer support initiatives, and provision of more integrated services to people living in the community with developmental disabilities. Closer integration of SUA and MH services is called for by stakeholders but also in research on the common roots causes (e.g., Adverse Childhood Experiences, trauma, social determinants); the developmental progression whereby SUA challenges are usually preceded by MH challenges in childhood and adolescence; and the very high co-occurrence in both adolescence and adulthood in the general population and those seeking help. Importantly, recent research by the MCHP has shown that in the context of the "double trouble" of co-occurring disorders, while MH challenges are usually the reason for seeking help, it is the SUA component that is related to higher use and cost of health service utilization over time. This speaks to the need for the proactive use of validated screening tools to identify SUA challenges in mental health and other health settings.

Also, with respect to the need for closer integration of SUA and MH services, it was clear in the consultations and the quantitative data that SUA services were seeing a significant proportion of people with mental health challenges and needing better access to mental health services. This was true in reverse fashion for mental health service providers, and both sectors were decrying the lack of access to primary health care for the people they serve. Thus, SUA/MH service providers share a lot of common experiences and challenges; hence the need for shared solutions and improved integration of services. A high degree of integration is needed in clinical teams working with people with very complex challenges (i.e. Tier 5) but also at the front door of the system in terms of fully integrated, centralized intake, screening and triage, as well as community-based teams. Timely access to consultation from psychiatry and psychology is also required, especially for Tiers 3 to 5.

Lastly, a range of collaborative service delivery models are needed to knit SUA/MH services closer together with, for example, primary care services, justice, family and social services and education. SUA and MH service providers alike voiced the need for more support from primary health care providers. MyHTs present an excellent opportunity to build closer integration of mental health services and primary care and there are other shared care models in the province that serve as excellent examples from which to learn and adapt. Going forward, however,

capacity for SUA must be included as a provincial standard for MyHTs. Community mobilization hubs are another, evidence-based approach to collaborative care that closely engage SUA/MH services with the justice system and other sectors in actively creating collaborative solutions at the individual level. An important consideration in all these collaborative care models is that support needs to be available to those professionals with less experience in SUA/MH but who are offering their services to support people with SUA/MH challenges. See also the [Strategic Direction 4.0 for Children and Youth](#) and the support for the youth hub model.

Recommendations:

Integration of SUA and mental health services

Integration to enhance overall capability and capacity

- 3.1 Develop integrated centralized intake for SUA and MH services, with separate processes for children/youth and adults, but both integrated in terms of SUA/MH, including the use of validated screening tools to identify SUA/MH issues, and with co-trained managers and staff.
- 3.2 Develop integrated and co-located community-based SUA/MH teams, with separate processes for children/youth and adults, but both integrated in terms of SUA/MH, including the use of validated screening tools to identify SUA/MH issues, and with co-trained managers and staff.
- 3.3 Undertake a focused Co-occurring Disorders Capability Assessment of MH services (RHA and funded agencies) and the province's SUA services (AFM and funded agencies) so as to determine the nature and scope of "slippage" of previously established principles and guidelines of CODI (e.g., parallel or sequential treatment pathways rather than integrated; restrictions on admission due to medication use) and develop goals and targets for quality improvement.
- 3.4 Increase access to, and coordination of, psychiatry and clinical health psychology diagnostic, treatment planning and therapeutic supports to MH services and supports as well as SUA services, including publicly funded service providers.
- 3.5 Ensure that additional system planning accounts for the full range of bio-psycho-social and cultural/spiritual services and supports that are needed in the treatment and support of SUA and MH challenges. This includes skill sets and experiences of key leaders and managers as well as meaningful participation of a wide range of community stakeholder, including people with lived experience.

- 3.6 Assess potential collaborative opportunities with the Department of Families for maximizing the use of the Manitoba Development Centre for people with SUA and MH challenges, including children and youth.

Integration to improve transitions across the lifespan¹¹⁰

- 3.7 Enhance program design and content as well as workforce competencies to work with older adults, recognizing the significant aging of people in services for some time (i.e., “aging in place”) and the long-term impacts of their SUA and MH challenges, including on physical health status and high risk of suicide.

Integration to improve access and coordination flow

- 3.8 Enhance system navigation services that assist those in their recovery journey and/or family members and other loved ones, to access and navigate the local, regional and provincial treatment and support system. The professional staff working in these navigator services must be cross-trained in SUA and MH. There is also an important role for peer-support workers and recovery coaches.
- 3.9 Improve coordination of services and supports that are provided by Manitoba’s mental health self-help organizations – MDAM, ADAM, MSS and OCDC - including exploring opportunities for administrative efficiencies.

SUA/MH and Provincial Health Services

Integration with primary care

- 3.10 Ensure, as a provincial standard, that people receiving SUA/MH services also have access to primary health care services.
- 3.11 Accelerate implementation of the MH component of the provincial MyHT initiative but with a renewed focus to also ensure integration of SUA services as a provincial standard.
- 3.12 Accelerate implementation of other approaches to collaborative (shared) care options, but with renewed focus to ensure integration of SUA services as a provincial standard.
- 3.13 Develop and initiate a provincial program for Screening and Brief Intervention in primary care services with a focus on alcohol, cannabis and depression, while ensuring service pathways are in place for support of those people screened and identified as requiring more intensive services and supports.

¹¹⁰ See also [recommendation 4.6](#) under Children and Youth Strategic Priority for improved transitions for youth to adult services

Integration with personal care homes

- 3.14 Increase capacity in personal care homes to support people with SUA/MH and/or behavioural challenges so that more people can be transitioned into these facilities from inpatient mental health units (e.g., SMHC, PsychHealth, Eden).

Other sectors and multi-sectoral coordination

System-level integration

- 3.15 Conduct a formal “systems audit” of barriers within and across sectors (both policy and programmatic) to service access, coordination and effective transitions. As a starting point, implement an initial process as a pilot initiative through the multi-sectoral Reference Group supporting this Strategic Plan. A key focus of this recommendation should be identifying barriers and potential solutions to the sharing of information across sectors/providers while staying within the boundaries of PHIA.

Sector-level integration

- 3.16 Enhance collaboration and service capacity of community-based, non-profit organizations, recognizing their enhanced flexibility (e.g., hours of service, use of mobile technology); enhanced connections to other community resources that can be leveraged, such as private foundations/grant funding and volunteers; and the local trust that community-members have in these services when they are both culture and neighborhood-based. These services should include the use of validated screening tools to identify SUA/MH issues, should ensure SUA is included in their mental health-oriented operational service plans, and should coordinate with RHA and AFM-based services.
- 3.17 Enhance the role of spiritually-based community services in collaborative SUA/MH partnerships at the community level and, in support of this direction, re-affirm and enhance the role of the Spiritual Health Care area of MHSAL in facilitating these community relationships and enhancing this critical aspect of treatment and recovery capacity for SUA/MH. This includes leveraging the work of this small but important area in bridging formal health services and traditional Indigenous approaches.
- 3.18 Support and accelerate the development of community mobilization hubs, for people with highly complex needs, involving the justice system and other sectors and ensure an inclusive focus on SUA.
- 3.19 Enhance transition supports for those being released from corrections to SUA and MH services and supports, including navigation support for access to health care, housing, and other basic needs.

3.20 Enhance and accelerate the coordination of services and supports provided to people experiencing both developmental disabilities and mental health challenges (from the Department of Families, RHAs, and contracted providers) and ensure an inclusive focus on SUA.

4.0 Mental wellness of Manitoba's children and youth

Throughout the system review, including the validation events, there was extremely high level of support for a Strategic Priority focused on children and youth. Many factors are behind this level of support, but perhaps most importantly is the evidence showing the very high rates of SUA/MH challenges, including attempted and completed suicide; the increasing levels of complexity, including social complexity such as high levels of gang involvement; and the comparatively low levels of funding for children and youth services. Since the evidence is also unequivocal about the common trajectory of MH and SUA challenges, with mental health challenges preceding in early childhood and adolescence, investments in children and mental health services and supports were viewed as both “treatment” and “prevention”.

In many respects, the Healthy Child Manitoba Office (HCMO) is exemplary of the kind of multi-sectoral approach that is needed to focus on the root causes of SUA/MH, while at the same time engaging in research and development activities to improve treatment and support services for children and youth. The main challenges we could identify with the HCMO model was the sheer breadth of its work, the need to ensure that the effective interventions that are being implemented can be brought to provincial scale, and the increasing investment in direct SUA/MH services that may signal some scope creep in relation to its core mission. That being said, the research and development work of HCMO is exemplary, and should remain firmly grounded in the development of best practices such as the Towards Flourishing program, which has gained international recognition. In addition, given its unique mandate and structure as an inter-governmental entity, HCMO is also well-placed to take on a larger role in the coordination of important activities signalled by this system review, particularly coordination of school-based programs and suicide prevention for children and youth.

A significant challenge voiced in many parts of the province is the difficulty accessing the services of the MATC. While the work of the MATC is exemplary in terms of its evidence-base, the organization may, in fact, not currently have the capacity to meet its provincial mandate and stakeholder expectations. Also, recommendations provided above to fully integrate SUA/MH centralized intake (Recommendation #3.1), also apply to the provincial SUA-specific Youth Addictions Centralized Intake (YACI) line operated by MATC for children, youth and

caregivers. This will also require re-alignment, but only following a fulsome assessment of actual youth treatment capacity and models in the province, including a thorough review of the long-standing accessibility challenges identified in some critically needed youth services (i.e., AFM's youth residential treatment facility (Compass) and the crisis stabilization beds at Hope North: Recovery Centre for Youth). In the case of Compass, these occupancy challenges are long-standing and require immediate resolution in light of the seriousness of the crystal methamphetamine situation in Winnipeg and other jurisdictions, and for which treatment capacity is needed beyond WMS and stabilization. In the case of Hope North, the occupancy challenges may reflect growing pains and the need for close engagement of youth and families in the region served by the facility to ensure it reaches its maximum potential.

Youth themselves also told us that significant changes were needed to existing models of care, with more flexibility needed in the location and hours of services, the complexity of intake and assessment processes, types of interventions and supports, and rules such as restrictions on texting. Indigenous youth in particular have unique strengths and needs which will be discussed in the following Strategic Priority 5.0 specific to the Indigenous people of Manitoba. Their needs do resonate, however, with the general feedback received that alternative models are needed, including land-based programs and other culture-based teachings and ceremony.

Listening to the voice of youth from newcomer and refugee families highlighted the significant challenges they face in bridging the viewpoints, values and unique stresses of their parents, and traditional and mainstream culture, and doing their best to fit in and be hopeful about a future here in Canada. They spoke of the challenges of bullying, preparing for, and finding, employment, and the enticement of gang involvement, all of which speak to the need for SUA/MH services and supports that are tailored to their needs. To do so, they need to be involved in the development of these services.

With respect to coordination of services, significant challenges were identified between services offered through the Department of Families and those funded through MHSAL and the RHAs. These challenges call for prompt attention. For example, with CYMH/SUA Crisis Services (MacDonald Youth Services, Marymount) outside of the health system, these CFS-funded agencies are struggling to keep trained clinicians, and they are stigmatized services because families who have "sick" children have to use CFS services, not health services for their children. Coordination of mental health services for children in care requires particular attention given their significant and unique needs, especially in light of Manitoba research that shows the longitudinal trajectory of these children and the scope and depth of negative outcomes in their future. The need for more coordinated services, if not fully integrated family-based service delivery models for children and the parents, was also cited as an important area for

development. A related challenge with respect to the coordination of services is the need for a focused provincial effort to support youth transitioning to adult services.

Last, but certainly not least, is the need to build upon the strengths of the youth hub model and leverage opportunities for support and scale up of this approach that brings so many services together under a youth-friendly approach to engagement and participation. The feedback received on the Norwest community youth hub model was very positive and consistent and speaks to the value of this approach for not only improving access but also integration of services including primary care and social services.

Recommendations:

Enhance capability and capacity

- 4.1 Significantly enhance the capacity of community SUA/MH services for children and youth, and, as above for adults, ensure a strong role for non-profit, community-based organizations in order to increase flexibility in the delivery of these services.
- 4.2 Increase support for gang-related services, including prevention services, recognizing the relationship between gang recruitment, participation and exiting, and the need for often rapid access to SUA/MH services and supports.
- 4.3 Review occupancy challenges at selected youth services, including the AFM Compass youth addictions facility and crisis stabilization beds at Hope North, with a focus on youth and family feedback that may help explain occupancy levels and contribute to improvements.
- 4.4 Reaffirm the role of the MATC as a provincial resource for youth and undertake a review of the adequacy of its resource capacity and current service mix to fulfill this provincial role. This should include consideration of YACI, to ensure functional, if not potential structural integration, with other centralized intake and access services for children and youth MH services.
- 4.5 Develop an integrated provincial plan to increase the coverage and coordination of services and supports provided to students in school, including, but not necessarily limited to, the work of the AFM, the RHAs, HCMO and mental health and addictions organizations, including the self-help organizations. Development of this plan should have significant youth input, including input into the actual content of school-based programs (e.g., how best to establish student trust, inclusion of a harm reduction component, use of self-management tools, and realistic portrayal of treatment access).

Improve transitions across sectors and the lifespan

- 4.6 Develop and implement a focused provincial program to support youth transitioning to adult services. This should include an assessment of the success of the CMHA Manitoba and Winnipeg program called Futures Forward and its potential as a provincial model.
- 4.7 Enhance service capacity and coordination of services for youth with developmental disabilities who are experiencing MH challenges, inclusive of a focus on SUA. This includes improved transitions to adult services, something which may require significant planning and service enhancement.

Improve access and flow

- 4.8 Building upon the successful experience of the NorWest Youth Hub and lessons learned from the experiences of other provinces, develop a provincial plan for scale-up of the youth hub model, or similar models of integrated youth services, taking advantage of support from philanthropy as it may be available.
- 4.9 Reconstitute support for the successfully evaluated (and effective) Emergency Department Violence Intervention Program (EDVIP), previously delivered at HSC.

Advance system-level integration

- 4.10 Undertake an internal review of the work of the HCMO to ensure this critically important, cross-sectoral entity is achieving its maximum impact. The review should aim to recommend strategies to better focus the work, including rationalizing its work in direct service delivery, and to ensure research and development projects with proven outcomes can be brought to scale using evidence-based implementation strategies, coupled with ongoing evaluation.
- 4.11 Consideration should also be given to a stronger role of the HCMO in the coordination of major provincial initiatives involving children and youth including, for example, through enhanced, provincial coordination of school services and supports (as noted above), and through leadership on the children and youth component of a renewed provincial suicide prevention strategy.
- 4.12 Given the high proportion of CFS kids with SUA/MH issues, including high suicidality, and the fact that current children and youth mental health (CYMH) and SUA services are delivered by CFS agencies, it is recommended that SUA/MH services for children and youth be brought under one umbrella where there can be at least functional integration of SUA/MH services as well as harmonization with and leveraging the current clinical specialization (i.e. psychiatrists, psychologists, CYMH Clinicians) of MATC and RHA CYMH programs.
- 4.13 Implement an education/information program for managers and staff of the CFS services of the Department of Families regarding SUA treatment with a view to expanding acceptable treatment options and more flexible criteria for treatment participation and success as a condition for children returning from care. This process should also facilitate

an integrated, whole family approach to the delivery of SUA/MH services that are required by both parents and children/youth rather than separate treatment and support pathways for each party.

5.0 Mental wellness of Manitoba's Indigenous peoples

The high percentage of Indigenous people in Manitoba is critically important context for the present Strategic Plan, as is their history of colonization and historical trauma, and ongoing challenges with respect to social determinants of health. These factors, combined with the clear evidence of very difficult SUA/MH challenges and the discovery made during the system review that for almost every service encountered, the largest percentage of people being served were of Indigenous background. This combination of factors called for a specific Strategic Priority focused on Manitoba's Indigenous people. More importantly, we believe the overall system of services will not improve significantly in terms of access or coordination without a concerted and sustained effort to better meet the needs of the province's Indigenous people.

We also heard from Indigenous stakeholders that this system review and the Strategy itself must be seen as part of a larger healing process facilitated by the Truth and Reconciliation Commission and the National Inquiry into Murdered and Missing Indigenous Women and Girls. Another fundamental building block is the First Nations Mental Wellness Continuum Framework, a framework that is highly consistent with the overall recovery-orientation that is grounding this new Strategy for SUA/MH services in the province. This includes an overall strength-based approach to implementation of the recommendations that follow.

Many of the specific issues identified previously with respect to the preceding Strategic Priorities resonated loudly, and often more loudly, with respect to the province's Indigenous people. This list includes, but is by no means limited to, the need for more local, and more flexible, services, including longer term treatment and pre-and post-treatment supports; the need for better integration of SUA and MH services; the need to fill specific gaps for youth and women; and a critical need for WMS, transitional stabilization to support access to treatment, housing, transportation and crisis services, including post-crisis healing opportunities. Indigenous stakeholders voiced the over-riding sense that the needs of their communities were far outstripping the capacity of the treatment and recovery support system to respond in a timely and effective manner.

Of the many issues brought forward unique to Indigenous people, two were particularly salient - the need for more culturally informed services, including land-based programs, and support for those community members whose customary language is their own native language and who have trouble understanding words and concepts expressed in English. Challenges identified with the workforce are noted below in Strategic Priority 6.0. Last, but certainly not least, was the "jurisdictional issue"— a fundamental challenge to be addressed going forward as it underlies significant issues related to access and coordination. This was one of the top priorities identified in the validation events and considerable hope and optimism was expressed

that this Strategy would open new doors and pave the way for significant progress in resolving long-standing perceived and real jurisdictional challenges with respect to SUA/MH services and supports.

Recommendations:

Increase trust and engagement

- 5.1 Acknowledge that this Strategy, including the anticipated process of engagement and implementation of recommendations for improved access and coordination, is a critical aspect of a larger healing process in the spirit of TRC Calls to Action 18-24, as well as the process of healing associated with the National Inquiry into Missing and Murdered Indigenous Women and Girls.
- 5.2 Actively engage Indigenous communities, organizations and elders in the process of refining and implementing the Strategy's recommendations as they impact local communities.
- 5.3 Work to ensure that Manitoba's people of Inuit heritage have equal access to SUA/MH services and supports, along with Manitoba's First Nations and Métis people.

Improve coordination and capacity

- 5.4 Establish a concerted cross-sectoral process to reduce perceived and real jurisdictional boundaries that challenge access to, and coordination of, services. The process of developing this Strategy, as well as any new opportunities and resources for working together (e.g., through Jordan's Principle), should be viewed as an accelerator of a new period of trust and collaboration based on shared beliefs and strengths among all partners, and should include an interest in wellness, hope and family/community health.
- 5.5 Acknowledge the importance of the First Nations National Mental Wellness Continuum Framework in guiding many of the Strategy's recommendations for improving access and coordination of services that support the four dimensions of physical, mental, emotional and spiritual health and wellness.
- 5.6 Focus collaborative efforts on ensuring equitable access to services, including RHA-based crisis services, for Manitoba's Indigenous people, irrespective of the community they call home.
- 5.7 Ensure treatment processes and content are culturally relevant and appropriate, including proactive offering of choice amongst services, including smudging, sweat lodge, the seven teachings, other traditional ceremonies, land-based services and evidence-based, culturally oriented ORT services.
- 5.8 Building upon existing strengths, including among Indigenous youth, implement a provincial training and education program to increase the cultural competencies of managers and staff in working with Indigenous people, including First Nations, Metis and Inuit.

5.9 Support the work of community elders, including capacity building among elders, to help them fulfill their traditional roles.

6.0 Healthy and competent mental health and substance use workforce

The first three Strategic Priorities and the corresponding recommendations (1.0 to 3.0) cover the “what” and “how” of system enhancement and Priorities 4.0 and 5.0 identify two important priority populations. Given these Strategic Priorities, the Consultant team determined that a final Strategic Priority was necessary to ensure that those who would, in large part, be implementing the details of the Strategy would be prepared and supported in their work – that is to say, a Strategic Priority to help prepare and support the workforce in SUA/MH work in the province.

Indeed, one of the most predominant themes that emerged throughout the system review was that the workforce itself represented one of the greatest assets of the provincial system of SUA/MH services and supports. SUA/MH managers and staff were consistently praised as “caring”, “passionate”, “dedicated” and “knowledgeable”. Such praise was often expressed alongside comments about the challenging circumstances and the limited resources available, relative to the increasing demands and stressful conditions of the work. Of particular concern to many stakeholders were issues related to safety and security, for example, within rural and northern EDs that are reportedly not well-equipped with infrastructure for private rooms or with security services to support agitated or distressed patients. To mitigate these concerns, standards of safety and provision of security are core elements of the SUA/MH hubs recommended above ([#2.11](#))

Another over-riding concern commonly expressed relates to the amount of change that is already underway, or anticipated, in the system (e.g., clinical consolidation, cut-backs in managerial positions, increasing safety concerns related to increasing meth use, and the impacts of both the Peachey report and the current Strategy). Therefore, an important implication for the Strategy, and its anticipated implementation, is the need to prioritize workplace wellness and to ensure an effective change management process is put in place to support managers and staff in the work ahead. One of the more specific concerns in this regard was the potential for a change in scope of practice pending recommendations for a more integrated SUA/MH team work. Experience from other jurisdictions that have worked on developing such integrated teams is to “go slow” and engage in proper planning. An important aspect of planning will be to identify the value of team work and the required competencies that are needed within the team as a whole for working with people at different levels of complexity (i.e., not every team member necessarily needs the same set of competencies). Cross-training for managers and staff to gain exposure to the “way things work” in the SUA/MH

services of their respective colleagues is a particularly valuable strategy. An upgrade to the core CODI training package was recommended.

A host of other workforce challenges were identified, three of the most important being the lack of clinical supervision, especially in the face of increasing complexity and severity of needs; the gradual erosion of education and training budgets; and recruitment and retention issues. While there is no easy solution to recruitment and retention challenges, particularly in the rural and remote areas of the province, providing professional supports and development opportunities, together with a strong emphasis on team work, was viewed as important contributors to high work satisfaction, and ultimately, to supporting retention and recruitment.

The many other challenges that were identified are best addressed in a comprehensive human resources plan, including, for example, the need for pay equity, standards with respect to caseload, qualifications and core competency requirements, and the need to bolster the workforce in key areas such as peer-support, recovery coaches and proctors. The Peachey report recommended an increase in the provincial capacity for clinical psychologists, a recommendation endorsed by the Consulting Team after gathering considerable input during the review process, and with the added caveat that roles are clearly defined and in the context of working in teams.

Another frequently cited concern was the level of training offered within various professional schools for working with people with SUA/MH challenges. Needs were seen as particularly high for work in SUA, for example, increased training for addiction psychiatry, psychology and nursing. The importance of proactive surveillance of physician prescribing of opioid medication to minimize risk was also reinforced.

Important legislative changes in 2009 concerning the regulation of social workers in the province has impacted the ability of other professionals to be similarly regulated and which is having some unforeseen negative consequences within the Manitoba workforce for SUA/MH.

Lastly, several Indigenous stakeholders, including those providing feedback in the on-line survey, articulated the importance of Indigenous staff, and recommended a concerted effort to support more Indigenous people to enter SUA/MH-related professions, a recommendation we have also endorsed below.

Recommendations:

Increased workforce capacity

6.1 Develop a comprehensive health human resource strategy that will address, but not necessarily be limited to:

- Maintaining a healthy and safe workplace with an overall focus on workforce wellness and supporting staff and managers through the anticipated level of change that will be required to implement the Strategic Plan, giving particular attention to support during the process of improving integration of MH and SUA services.
- Increasing the size and diversification of the workforce, including:
 - the numbers of peer support workers and recovery coaches
 - the number of proctors
 - the number of psychiatrists in the system, in particular those trained in General Psychiatry, Addictions, Forensics, and Geriatrics, and to a lesser extent Child and Adolescent. The current number of 12 residents per year needs to be increased as well as an increase in the number of psychiatrists engaged in the teaching hospitals to ensure adequate supervision and training
 - ensuring an equitable distribution of psychiatrists across the RHAs, that is appropriate to population size and community context, including a review and update of the FTEs per region provided in the Peachey report¹¹¹
 - the number of clinical psychologists to the level of the national guideline (as recommended in the Peachey report). An increase in the number of psychologists is required and should come with clear role clarification including team-based work, consultation for assessment, delivery of specialized evidence-based therapy appropriate to their level of training, and capacity building for other team members. An increase in addictions training capacity within the Clinical Health Psychology program is also required.
 - nursing positions at multiple levels but particularly at NP, RPN, and PEN levels
 - the number of managers and staff at all levels from Indigenous backgrounds
 - the overall cultural diversity of managers and staff, including representation of newcomers and refugee populations
 - formal relationships with Indigenous elders
- Implementing strategies to recruit and retain managers and staff, especially in the rural and remote areas of the province and, in this context, also enhancing the opportunities for student practicums.
- Developing and ensuring ongoing updates of a common orientation package for staff that provides an overview of the Manitoba SUA/MH system, and for key partners, with an emphasis on roles and responsibilities and processes for accessing and transitioning

¹¹¹ Discrepancies were reported to the Consultant Team such that some part-time FTE positions were counted as Full FTEs.

across services. This should NOT be in a simple “directory format” but rather should be a more descriptive resource, including on-the-ground advice for accessing and navigating the system. An adapted version of this resource should be developed and made available to other professionals working in related sectors.

- Delineating core competencies, including cultural competencies, clarifying roles and scopes of practice in relation to these required competencies, and aligning competencies, in part, with required services and functions within the service delivery tiers in the proposed provincial framework ([Figure 2](#)).
 - Core competencies and training levels should be identified for all staff, running the gamut from staff responding to calls through central intake, all the way to those staff engaged in complex and long-term therapy for severe trauma.
 - Competencies and scopes of practice required for *integrated* SUA/MH work specific to intake, screening, assessment and the delivery of community-based services, should be specifically examined.
 - Improving structures and processes for clinical supervision.
 - Developing strategies to encourage team-based services and supports to support higher work satisfaction.
 - Assessing the capacity and training needs of managers and staff *receiving* distance-based consultation supports from clinical SUA/MH experts, especially in First Nations communities and rural and remote areas, which may also be experiencing recruitment and retention challenges. Support is also needed in using and maintaining telehealth equipment.
 - Increasing financial support for training and continuing education.
 - Assessing and working to resolve pay equity challenges, including differences between community and hospital, mental health versus SUA work, and publicly-funded SUA/MH service providers.
- 6.2 Implement a cross-training program for managers and staff to support their working together in integrated SUA/MH teams and facilitate collaborative service delivery with other sectors
- 6.3 Develop strategies to enhance the SUA/MH skills of a range of key professionals, including primary care physicians (in both SUA/MH); PENs (especially SUA), and clinical psychologists (especially SUA).
- 6.4 Ensure adequate consultation is available to support collaborative and shared care arrangements with primary care
- Pending evaluation results of pilot work enhance the provincial RACE program to include SUA
 - Explore ECHO, a primary care capacity building program developed in Ontario.

7.5 Enabling supports for Manitoba’s SUA/MH system

To deliver against the six Strategic Priorities outlined above, the Manitoba SUA/MH system must also focus on developing its capabilities in several areas that we call “enabling supports” – important areas of focus that are needed to support the system’s efforts to implement this Strategic Plan. Throughout our consultations with members of the public, service and support providers and other key stakeholders, we heard that the SUA/MH system must build enabling supports in four key areas, listed below.

7.0 Funding and accountability for quality outcomes

Funding: An important aspect of the evolution to the current state of the SUA/MH system with respect to access and coordination has been the escalating level and complexity of individual, family and community needs, and the limited increase over time in resources to respond to these needs in a timely and effective way. The qualitative feedback and the very long wait times reinforce the conclusion that the needs and requests for treatment and support have far outstripped system capacity. Stakeholders also related several events that put a personal and often tragic face to this disparity between need and capacity.

While an infusion of funding alone will not “fix the system”, some investments will be needed. While we are aware of the need for fiscal restraint in the Manitoba context, a need reinforced in previous and the current government budgets, we highlight the **strong business case** for these additional investments, the **size of the funding gap**, and the **length of time the disparity between need and capacity** has continued. We recommend below bringing the level of investment up to be roughly on par with other Canadian jurisdictions, plus a marginal increase to correspond to the significantly higher level of need identified in this system review compared to other Canadian Jurisdictions. Within the context of a detailed, staged plan to operationalize the many recommendations offered in this provincial Strategic Plan, we encourage a multi-pronged approach to securing resources and making the required investments. This can include, but need not be limited to, re-investing other health dollars or pooling resources from other government departments as part of a “whole-of government” approach; preparing for and leveraging opportunities for new investment that may come through federal commitments for mental health, including housing; and redirecting savings that may accrue in implementation of some of the recommendations, particularly through more integration of SUA and MH teams, reduced out-of-province expenditures, and reduced Medevac costs.

In addition to an across-the-board increase for the province’s SUA/MH services and supports, targeted funding is needed to enhance the capacity of children and youth services (see [Section 4.0](#)). We also suggest—based on wait time data and level of need compared to current capacity to respond—some immediate directed funding to enhance services for the treatment of SUA, eating disorders, and trauma.

Attention also needs to be given to how psychiatrists are reimbursed so as to attract and maintain a cadre of these professionals working in the public health system and not solely in private practice. Based on expert feedback, we suggest the province move to a more blended funding model that includes both a salary and fee-for-service billing component and, when appropriate, special contract. Another, somewhat related, issue is the need to develop provincial policy that would require other parts of government such as Justice/Corrections to contract for psychiatric services through the public system, rather than through independent, fee-for-service psychiatrists, so as to maintain equity and facilitate retention of psychiatrists in the public system.

Governance and accountability: In addition to enhanced funding support, many aspects of the system review pointed to a need for enhanced governance and accountability structures. This is not meant to take away from the many recommendations for improved partnerships and collaborations that will be required in the “whole-of government” and “whole-of-society” approach, nor to downplay the importance of many fruitful partnerships and collaborations that currently exist. That being said, we concur with the general observations of broader health system reviews, such as the KPMG and Peachey reports, about the multiple “siloes” in the Manitoba health system and find the SUA/MH system to be a good example of this at a sub-sectoral level and with multiple levels of contracting and sub-contracting. We illustrated this complexity in a previous section of this report that aimed to map out these complex arrangements (see [Figure 3](#)).

The development of Shared Health is a direct result of the larger system reviews that preceded the present work, and is intended to simplify several aspects of the overall governance structure, in part by bringing more of a province-wide focus to many functional aspects of health system management and service delivery. We support this general direction as it applies to the SUA/MH system of services and supports. That being said, it is challenging to offer specific recommendations regarding provincial structures to support this general direction since the work of Shared Health is still evolving, particularly the articulation of roles and responsibilities that will remain in government and those that may be best contracted to Shared Health. We do recommend below, however, a more streamlined governance model for the existing provincially-mandated SUA/MH organizations and we suggest this governance model be seriously considered in the context of the evolving roles and responsibilities between Shared Health and MHSAL.

Recommendations

Enhance financial support to build required capacity

7.1 To ensure there is sufficient financial support to make a significant difference to access and coordination of services in Manitoba, and to translate these enhancements to quality outcomes, a graduated increase in funding over 3 years is recommended to reach the

Canadian guideline of 7.2% of total health budget, plus an additional 2% to acknowledge the historical gap in funding and the significantly higher severity across the vast majority of indicators of need examined in this report. Therefore, the recommended three-year target is 7% to 9% of the Manitoba health budget being dedicated to SUA/MH treatment services and recovery supports.

- 7.2 Give immediate funding priority to the expansion of services for children and youth services and, for adults, to services for people with SUA, eating disorders, and those who have experienced severe trauma.
- 7.3 Ensure that all future planning activities leverage funding opportunities at the federal level for mental health, including dedicated funding for a range of housing with supports for people with SUA/MH challenges. Any increased funding for long-term care/personal care homes should be reviewed for its ability to support recommendations in this Strategic plan, particularly transitioning people out of acute and chronic care mental health facilities when appropriate.
- 7.4 Develop contingency plans for increases in costs for contracted services, specifically mental health residential care.
- 7.5 Include in future planning activities an assessment of infrastructure needs and the development of related short-medium and longer terms priorities. An accelerated priority should be given to improvements very much needed for Rosaire House in NHR and Eden Mental Health Centre in SH-SS.
- 7.6 Revise the funding models for psychiatry to ensure competitive reimbursement to support retention in the public services sector. For psychiatry, this should include blended models of funding through salary, fee-for-service billing and contracts to support community-based service providers. The funding models for physicians providing ORT services should also be reviewed and revised to incentivize community physicians to take on this critically important role.
- 7.7 Develop a policy that would require other parts of government such as Justice/Corrections to contract for psychiatric services through the public system rather than through independent fee-for-service psychiatrists so as to maintain equity and facilitate retention in the public system.

Improve governance, planning and accountability

- 7.8 Create one SUA/MH governance structure that will embody the current entities of the SUA/MH system that have a provincial mandate, including but not necessarily limited to, AFM, SMHC, MATC, and the HSC. Eden Mental health Centre a private facility should be encouraged to join through commissioning processes. This provincial body should be branded as the Manitoba Addiction and Mental Health Program and signal a new beginning for the **integrated** planning, delivery and performance measurement of provincial SUA/MH services with a strong commissioning and coordinating and integrative

mandate with SUA/MH service agencies, including RHAs and non-profit and private community service providers.

- Ensure in the creation of the new governance structure that all incoming entities be administered by a common administrative authority, that is to say, they should NOT retain their separate Boards of Directors, CEOs etc. but rather function for all intents and purposes as one a new organizational entity, which may of course, have different component parts organized by function and/or speciality.
- Ensure that the new governance structure, including its leadership, supports and facilitates a broad bio-psycho-social, cultural/spiritual approach to SUA/MH so as to ensure the needs of all Manitobans can be met with a comprehensive approach, for example, not dominated by any one perspective. This would include the development of an organization and system culture in line with the vision and principles recommended in this report.
- Use a co-leadership model to further ensure a broad approach to governance, planning and operations, using for example, the current model within the WRHA Mental Health Program for co-leadership under a Medical Director and a Director with responsibility for community/psycho-social aspects of the new provincial program.
- Incorporate standing Advisory Structures with representatives drawn from diverse stakeholders, including, but not limited to government departments, persons with lived experience of SUA/MH challenges, their families, and Manitoba's Indigenous people and youth.

7.9 Strengthen overall system-level planning, commissioning, accountability and ongoing quality improvement structures and processes so as to ensure the removal of barriers to access and coordination and create an equitable **provincial** system of SUA/MH services and supports.

7.10 Develop a provincial vetting process such that new internal or external service-enhancement proposals can be reviewed in a timely manner for consistency with a provincial preventive and clinical services plan which continues to prioritize and operationalize the recommendations in this Strategic Plan. This review process should include an expedited assessment of all pilot projects and program evaluations for their balance between system reach and effectiveness, health equity, and potential for scale up.

7.11 Establish a cross-Ministry government table that is tasked with monitoring and addressing barriers experienced during the implementation of this Strategic Plan.

7.12 Leverage the combined strengths and assets of a more integrated SUA/MH provincial program to elevate and maintain its priority within the wider health care system and to facilitate a whole system/multi-sectoral approach.

Develop provincial standards

- 7.13 Develop provincial standards to ensure equitable access to services across the province, and optimal coordination of services, for example through rationalized admission criteria, caseload size and occupancy rates, and communication and transition supports when people are discharged and/or transferred across regions or smaller jurisdictions. Provincial standards are also needed concerning scope of practice, core services, and clinician choice of interventions to be offered to people seeking help.
- 7.14 Instate a provincial licensing process and related standards for privately operated residential SUA/MH services.

8.0 Evidence generation / translation to policy and practice

A fundamental principle embedded in the Strategic Plan going forward is to apply the best available evidence in both system design and the delivery of treatment and recovery support services. During the course of the system review, the Consultant Team was impressed with the scope and quality of research and evaluation work undertaken within the province. This includes the capacity for generating new knowledge (e.g., MCHP, HCMO, University of Manitoba/HSC-based researchers); the capacity for research synthesis (all of the above but also including, as examples, MHSAL, RHAs, AFM, CMHA); and the capacity for program/policy evaluation and quality improvement (all of the above but also including several other service providers, such as SMHC and BHF).

These are all critical functions that need to continue to be supported for the implementation of the Strategic Plan as well as future planning activities. In this regard we anticipate an emerging role for Shared Health in harnessing these various strengths with a clear link to system-level clinical and preventive services planning.

One key learning during the review process is the challenge that has been experienced in the province going from “pilot projects” to implementation and scale up. It will therefore be important, going forward, to build capacity for implementation science as an evidence-based approach to going from research to practice in a thoughtful and sustained manner. An important tenet of implementation science is that this work begins when new research or evaluation activities are first conceptualized with a clear “go/no go” decision point that takes multiple factors into account, such as system readiness and expected payoffs in terms of reach of services and quality outcomes. The distinction between “contact coverage” and “effective coverage” will be a useful aspect of decision-making for supporting new system-level projects—that is to say, will a new services or intervention bring more people into the system (contact coverage) or will it increase the level of actual treatment and support and effective outcomes (effective coverage)?

In addition to the structured processes of implementation science, other methods are also available that bring people together to process a key challenge, referred to as a “wicked problem” in the language of complex adaptive systems. This approach, referred to as “open

space technology”, is recommended as part of the provincial toolkit for problem analysis, problem solving and implementation.

Recommendations:

Enhance evidence base

- 8.1 Further enhance the significant strengths in both the current SUA/MH sectors for reviewing evidence and translating knowledge to practice, through a more integrated SUA and MH focus, for example, by developing common infrastructure, tools, and methodologies.
- 8.2 Assess the evidence-base for models/strategies for improving transitions of youth to adult services, including their suitability for the Manitoba context. This includes the CMHA-supported Futures Forward program as noted under the Strategic Priority for children and youth (# 4.6)
- 8.3 Assess the evidence-base for e-mental health apps and mobile technologies for SUA/MH supports, particularly e-supports for self-management, and invest in these tools and with evaluation support to ensure effectiveness in the Manitoba context.
- 8.4 With a view to significantly increasing the overall coverage of the treatment system, assess the evidence-base for low threshold interventions for the treatment of mild to moderate SUA/MH challenges, including interventions incorporating physical exercise, yoga, and mindfulness meditation, as well as spirituality-based services across the severity spectrum that are consistent with an overall recovery and wellness approach.

Conduct reviews/evaluations in support of the Strategic Plan

- 8.5 Review the experience to date with the “pilot” implementation of RACE, including its potential uptake and appropriateness for rural and remote areas of the province and current barriers to incorporating consultation expertise related to SUA. Concurrently, assess synergy with, and potential of, Ontario’s ECHO program for building capacity in primary care settings.
- 8.6 Evaluate the Winnipeg-based Priority Home initiative with a focus on determining its accessibility to people with mental health challenges, including co-occurring disorders, and its viability as an alternative to the successfully evaluated (and successful) WRHA Home-based Mental Health Teams.
- 8.7 Finalize the current internal AFM residential services review that is focused on increasing occupancy and reducing wait times. In particular, assess the resource implications of standardizing all treatment cycles in residential programs as “open cycle” and building in variable (longer) lengths of stay.
- 8.8 Conduct a formal review of out-of-province service utilization for SUA with a view to (a) developing and adhering to more transparent criteria with respect to appropriateness and (b) setting targets for a gradual reduction, as appropriate, in order to repatriate the cost savings to services within Manitoba.

8.9 With a view to developing concrete quality improvement plans, initiate *external review(s)*¹¹² of AFM’s residential and community services with a focus on assessing:

- the reliability and validity of current screening and assessment tools (e.g. SASSI) and individualized treatment planning/matching processes, including matching of clients to services based on personal level of readiness to change and environmental factors such as a formal mandate to seek help.
- the appropriateness of the current heavy reliance on 12-step facilitation in AFM residential programs, identifying opportunities for more flexible program content, and identifying the staff competencies and training that are needed for the delivery of behavioural and other evidence-based treatment approaches.
- co-occurring disorders (COD) capacity with a goal of *re-aligning* with best practice (e.g., use of validated screening tools for common mental health challenges; variability in restrictions on admission to SUA treatment based on medications being used for mental health challenges; basic competencies for, and access to, mental health supports);
- the appropriateness of current models of service for youth treatment.
- the evidence base for the extensive use of acupuncture in AFM programming.
- organizational capacity for the delivery of trauma-informed care, including both organizational processes as well as the nature of specific interventions being used;
- consistency and depth of use across sites, of culture-based approaches for Indigenous clients desiring access to traditional practices in their healing process.

Enhance evidence-based implementation

8.10 Support innovation in service delivery with strong evaluation processes as well as careful attention to potential scale-up and implementation.

8.11 Ensure the use of evidence-based approaches in the operationalization and implementation of the recommendations in this Strategy Plan, including a systematic assessment of past attempts at bringing successfully evaluated interventions and service delivery models to scale across the province.

8.12 Building upon existing relationships and collaborations, apply “open space technology” to explore solutions to the following significant cross-sectoral coordination challenges:

- Improving coordination and collaboration between CFS-funded and health-funded SUA/MH services
- Reducing barriers related to jurisdictional challenges between Federal/Indigenous and provincially-funded services

¹¹² Some external reviews may require special expertise and need to be done separately (e.g., cultural competency, co-occurring disorder capability, youth treatment).

9.0 Surveillance, monitoring and performance management

The need was expressed at multiple levels for improvements in “data systems”. These improvements generally fell into one of the following three areas:

- the need for better population-level surveillance, sometimes expressed as “*making better use of the extensive data we have in hand*”, that is tied to the need for a more structured but rapid response system to deal with emergent challenges (the current crystal methamphetamine crisis being a case in point).
- Improved and more synchronized clinical information systems to enroll people in services and enter descriptive information such as demographics, diagnosis and individual/family context, as well as case notes and discharge plans. A myriad of such information systems was encountered within and across the RHAs as well as AFM, SMHC and, of course, the many publicly funded agencies. In more than one context, paper records are still being used and information is being shared by handwritten notes/letters and fax.
- Related to both of the above challenges is the lack of any consistency in the definition and measurement of performance metrics such as wait time, occupancy or ALC.

The old adage, “if you can’t count it you can’t manage it”, could not have been more evident across the province, including in the challenging experience of the Consultant Team in compiling a consistent set of operating data for purposes of this Strategic Plan. More than one apology was forthcoming from senior managers in the system about their lack of basic data, for example, related to frequency of use of EDs for SUA/MH challenges, and wait times. While challenging for various reasons in this review process, it confirmed the need to highlight this major gap in our recommendations.

In going forward, we have made the assumption that Shared Health will assume at least some new responsibilities for province-wide service delivery performance measurement, and possibly joint responsibility with MHSAL for performance metrics related to the implementation of the Strategic Plan itself. To that end, we suggest performance metrics be developed related specifically to access and coordination of services (e.g., a consistent measure of wait time; successful transition between key elements of the treatment continuum, such as WMS to residential or community-based SUA treatment; and successful hospital to community discharge). We also recommend synchronizing the development of some metrics with other major provincial initiatives, such as efforts to reduce wait times in ED and MyHTs. It will be important also to link provincial indicators to emerging national indicators for SUA/MH, as this may facilitate leveraging federal funds for SUA/MH services and supports, including housing

supports. Finally, it will be important to keep top of mind that “data” should be the basis of ongoing quality improvement efforts.

Recommendations:

Enhance Information Management

- 9.1 Support and accelerate relevant workstreams currently underway to create a provincial plan for reducing the number of independent, service delivery information systems with a view to streamlining the input and sharing of information while enhancing quality outcomes and minimizing risk.
- 9.2 A system-wide audit of opportunities for synergies and enhancements, including strategies to ensure connectivity to wider e-Health strategies in the province aimed at developing a common electronic medical record (EMR).
- 9.3 Strategies to maximize the value-add of existing information systems focused on enhancing quality of care outcomes (e.g., the Provincial Discharge Protocol related to attempted suicide and the B Sharp client information system being adopted in NHR), and to reduce service delivery inefficiencies.
- 9.4 Place a temporary province-wide moratorium on the development and/or purchase of new service delivery information systems during the creation of this provincial plan focused on information management.

Enhance performance measurement

- 9.5 Develop a performance measurement framework to track progress and outcomes specific to the implementation of this new SUA/MH Strategic Plan.
- 9.6 Develop an integrated provincial performance measurement system across SUA and MH service providers with common metrics and definitions of key indicators related to service access and coordination, as well as costs, processes and outcomes.
 - Aim to strengthen planning and accountability at both the service and system levels, as well as strengthen quality improvement initiatives.
 - Synchronize the development of metrics, as applicable, with related provincial initiatives, such as efforts to reduce wait times in EDs and MyHTs, and, at the national level, with the development of indicators for SU/MHA.
 - Ensure that the collection of high quality data be the basis of ongoing quality improvement efforts
- 9.7 Strengthen key relationships at the national and inter-provincial levels so as to leverage, and be in synch with, efforts to develop national-level performance indicators for SUA and MH services, thereby enhancing opportunities for comparability and benchmarking.

10. Community engagement and change management

A common theme across all the site visits, consultations and validation events was that this review process “*feels different*”, as participants input reflected on the high level of engagement. It is important to maintain this level of engagement going forward and several recommendations are offered in this last Enabling Priority. Fundamentally, a carefully planned and implemented change management process is required. There are several critical ingredients of this process, but one of the most important will be to respect the challenges that many in the workforce have already faced in terms of the many changes to their work in recent years and months. To that end, it would be mindful to follow the mantra expressed in the recent wait times report on the EDs to “Hurry up and go slow!” (see [Recommendation 6.1 point #1](#), above)

Some of the most challenging aspects of the work ahead may be the closer integration of SUA/MH, at multiple levels. The experience in other jurisdictions implementing similar integration processes has been to recognize that this is as much, if not more, a culture shift, than a purely operational one, and that during this process, special attention needs to be given to ensuring the SUA work remains highly valued, as this is sometimes lost in the larger world of “mental health”.

We also heard and acknowledge that another key principle going forward will be to ensure that people with lived experience, including family members, continue to have a voice in system planning and performance assessment. Advisory structures will need to be constructed and linked to MHSAL to support the “whole of government” approach, namely a multi-sectoral advisory or task group. Within MHSAL, there is also the need to retain a defined project management function, with links to this advisory function and informed by strong change management supports.

We also suggest, however, that another advisory function be linked to Shared Health to the extent it assumes responsibility for the next phase of operational, clinical and preventive service planning, and performance measurement. At this level, multi-stakeholder representation will again be important, including people with lived experience. We also suggest a separate advisory group comprised of youth, including Indigenous youth and youth from the newcomer/refugee populations. Consideration should also be given to the creation of a “Provincial System Support Group” within Shared Health to provide dedicated support to any new provincial SUA/MH program, incorporating support to these advisory structures, as well as supporting change and project management, performance measurement, development of standards, knowledge exchange, and implementation-related activities.

Recommendations:

Maintain momentum and engagement

10.1 Building upon the extensive engagement and consultation process embodied in the development of the Strategic Plan itself, ensure continued participation and engagement from several key stakeholders in the implementation and evaluation process. This can include:

- Ongoing communication via web updates, special bulletins, and briefings.
- Participation on standing advisory committees for the Strategy as a whole, as well as for special projects (see below).
- Inter-governmental committee or task group supporting MHSAL
- Ensure active engagement with different communities as no one representative should carry the responsibility of speaking for everyone from a group

10.2 Ensure meaningful participation and engagement of youth, people with lived experience, family members, people with Indigenous backgrounds, and people from marginalized populations.

- There should be two representative, stakeholder-based standing advisory committees supporting the work of Shared Health (one for adults and a separate one comprised of youth).

Support for project management

10.3 Utilize well-defined change management strategies, including setting targeted goals and outcomes for different stages of implementation and for different components.

- Within MHSAL, there should be a defined and supported project management function, with dedicated staff focused on those projects/activities that include a strong inter-sectoral, cross-governmental component.
- Within Shared Health, we recommend a “SUA/MH Provincial System Support Group” to provide dedicated support to any new provincial SUA/MH program, incorporating support to the above advisory structures, as well as supporting change and project management, performance measurement, development of standards, knowledge exchange, and implementation-related activities.
- At multiple levels, acknowledge and implement mechanisms to support the culture shift that will be required for closer integration of SUA/MH, with particular attention given to ensuring that SUA work remains valued and is not “lost” in the larger world of mental health.

Short-term priorities/ Blueprint Action Plan:

It is very challenging to identify short term priorities without the benefit of the more detailed operational, clinical and preventive plan that will follow from this Strategic Plan, as well as a clearer sense of the direction for the potential structure of Shared Health and the sharing of roles for planning and implementation of different aspects of the Strategic Plan with MHSAL. On the one hand, there is a need to deal with some immediate crises such as suicide and suicide attempts, continued overdose deaths, and the increasing number of complex and challenging crystal methamphetamine presentations to EDs, the Crisis Response Centre and other services. On the other hand, caution is certainly needed in terms of continuation of the past approach of “plugging the holes in the system” without the benefit of a broader plan and more certainty over governance structure and roles and responsibilities. But there is much to be done and the best way to start is... well – start!

Short-term priorities have been considered in three sub-groups – all concerned with improvements to access and coordination:

- Priorities for enhancement to services and supports
- Priorities for immediate review and evaluation
- Priorities for development of provincial initiatives

(a) Priorities for enhancement to services and supports

One way forward is to capitalize on background work and momentum already gained for system enhancements that are consistent with the Strategic Priorities.

1. **Enhance the SUA continuum of services (#2.6 and 2.7)** - Begin building, in each of the RHAs, a continuum of medical and non-medical WMS services connected to post-WMS stabilization to facilitate treatment entry, and define pathways to treatment and post-treatment supports. As a part of this initiative, locate the shared Nurse Practitioner in the Men’s and Women’s WMS in Winnipeg, so as to facilitate more rapid access to medical clearance.
2. **Develop and begin implementing the provincial mental health and SUA regional focal points (# 2.11)**. Immediate needs are SUA and MH supports located in EDs in the hubs and more timely access to acute psychiatric beds at SMHC for residents of IERHA.
3. **Resolve the issue of lack of security at Eden Mental Health Centre (#2.28)**
4. **Move forward with the development of additional integrated youth hubs/services (#4.8)**

5. **Introduce Peer Support in the CRC with confirmed capacity for SUA supports (#2.10)**
6. **Launch an additional PACT Team in WRHA (#2.19)**
7. **Increase ORT capacity through provincial RAAM clinics (#2.17)**
8. **Enhance capacity for SUA/MH supports to newcomers and refugee (#2.25)**
9. **Enhance coordination of forensic services between SMHC and PX3 (#2.21)**

(b) Priorities for immediate review and evaluation

- a. Review the experience to date with implementation of RACE, including uptake and appropriateness for rural and remote areas of the province and current barriers to incorporating consultation expertise related to SUA. Concurrently, assess synergy with, and potential of, the Ontario-based ECHO program for primary care capacity building.
- b. Finalize the current internal AFM residential services review with its focus on solutions to increase occupancy and reduce wait times. In particular, assess the resource implications of standardizing all treatment cycles in residential programs as “open cycle” and building in provision for variable (longer) length of stay.
- c. Evaluate and resolve ongoing occupancy challenges with respect the AFM Compass youth program.

(c) Priorities for development of provincial initiatives

Priorities are identified in the following order:

- Addressing jurisdictional barriers for Indigenous people
- System audit re rules of engagement
- Identifying feasible options for transportation support

8.0 Summary and Conclusion

In the process of conducting the system review to arrive at this completed Strategic Plan, the Consultant Team conducted a very “deep dive” into the Manitoba SUA/MH system of services. Through several processes, including an extensive document review, the compilation of a host of indicators of community needs, an on-line survey that was extremely well-received by the general public and service providers alike, and a host of interviews, site-visits, consultations, discussions, and validation events, we developed a comprehensive picture of the “Current State” and the “Context” for going forward. During this almost one-year process, we retained a strong focus on issues related to access to, and coordination of, SUA/MH services, while also allowing wider conversations to occur that would inform gap analysis and recommendations—for example, the importance of the social determinants of health and the historical trauma that impacts Manitoba’s Indigenous people to this day.

As we draw the work on this Strategic Plan to a close, we would be remiss not to emphasize the picture of the extremely high level of need and complexity that emerges from our synthesis, as well as critically important regional and population-specific disparities. It is also important to keep focused on the often tragic individual and community stories that underlie this barrage of statistics.

We also identified many challenges related to access and coordination, many of which have been identified previously (e.g., a critical need for more WMS services and ORT; very high rates of suicide or suicide attempts), and others that emerged during the project itself (e.g., increased presentations of crystal methamphetamine-induced psychosis in EDs and the CRC). Such emergent issues remind us that health systems are indeed “complex adaptive systems” that require readiness and adaptability on the part of leadership and the many service providers involved. It’s the nature of the world we all live in. Throughout the project, we were also reminded of the heavy toll that alcohol continues to take on almost all segments of Manitoban society, as well as the challenges accessing treatment in a timely manner, especially for women.

We initiated the system review with a set of key principles that helped guide our review, for example, by structuring the analysis of the massive amount of qualitative data from the on-line survey to highlight needs and gaps in the system according to these principles. These principles were also our starting point for key system design features and they eventually evolved into the core principles and Strategic Priorities of the Strategic Plan itself. Examples, include the focus on population-based planning and the use of the tiered framework; a recovery-oriented system that focuses on wellness, healing and hope; holding strong with a trauma-centred approach, recognizing trauma as the primary root cause of the SUA/MH challenges experiences by so many people; and services that are client/family centred, harm-reduction focused, and welcoming and respectful. These are words that are written into the Strategy with deep intention behind them, as they reflect the voices of the many people contributing their

perspective and their stories along the way. They are principles that embody how one works in this field and how one should turn the Goal, Vision, Strategic Directions and Recommendations into day-to-day reality of implementation. The journey toward the completion of the Strategic Plan also revealed the historical trajectory of the system, a trajectory that explains in large part the “current state” and the many challenges of access and coordination. It’s a trajectory propelled by multiple “drivers”, many with deep historical roots such as colonization and the residential schools, de-institutionalization, literally thousands of children-in-care with well-documented devastating impacts, increasing availability and diversification of psychoactive substances in the community, and the increasing social complexity of people’s lives. The reduction in stigma and discrimination has also brought more people forward for help, as has the Truth and Reconciliation Commission. All of this is being managed with much the same resource base as was set decades ago during de-institutionalization—a *perfect storm*, if you will. Over time this has led to well-meaning efforts to increase access to services while, at the same time, contributing to considerable protectionist behaviour of many service providers aiming to work within their mandate with the resources they have available. Notwithstanding the many excellent examples of collaboration and partnership that we identified, from the perspective of individuals looking for help for themselves or a loved one, the rules of engagement seemed stacked against them; seemingly designed primarily to “keep you out” rather than “welcome you in”. Certainly, this was strongly reinforced by members of the general public and service providers who responded to the on-line survey. The comprehensive wait time data, assembled for the first time for the purposes of this project, further reinforce the view of the survey respondents that the system is just not able to meet the current level of needs and help-seeking, and, further, that, if you can manage to get into the system through one of the many doorways, it’s another matter entirely to access concrete therapeutic assistance. That’s a longer wait still. Pathways, or stepped services, are challenged by gaps in the continuum or insufficient capacity, for example, community mental health services to step people down from acute psychiatry or PACT teams.

This Strategic Plan is a fresh start forward for the province of Manitoba and sets out a bold agenda of system enhancement. The system is not going to improve overnight – it took a while to get to this current state – nor will it occur without a determined “whole-of-government” and “whole-of-society” effort that recognizes this is indeed “everyone’s business” and, more importantly, everyone has to own a share. Everyone also stands to gain because the business case is so strong, not only for working together, but also for making investments.

Six Priority Directions are established which together can make a difference to Manitobans. The **population health approach** will ensure an operational plan is put in place that directs assistance to people of all levels of severity and need, including those with less serious problems, so we can turn the tide before the challenges become costlier, not only to themselves and their families, but also Manitoban society as a whole. Our two Strategic

Directions focused on the **gaps in access and a more integrated continuum of services** take a comprehensive but measured approach to dealing with the many challenges we heard along the way, including the need for better integration of SUA/MH services, as well as better coordination with primary care, justice, social services etc.

The intentional focus on **children and youth** and their families as a priority population recognizes the amount of work to be done, as well as the critically important preventive impact of investing in their needs, and capitalizing on their strengths, at a young age. It's an investment for the present as well as the future. The second priority population, and the focus of the fifth Strategic Priority is Manitoba's **Indigenous people**, in recognition of their unique needs and strengths and community resilience, and in particular the significant work to be done on jurisdictional challenges. The way forward is through trust and collaboration, and this Strategic Plan is intended to be a springboard to make a significant difference the lives of Indigenous people of Manitoba, no matter where they live in the province. All communities have been touched in very challenging ways and there is much to be done, that can only be done through mutual respect and cooperation.

The final Strategic Priority focuses on the health and well-being of the **workforce in the SUA/MH system** – the backbone of the system in so many respects. They told us they are working in difficult circumstances, with limited resources. Recently, many have also experienced a lot of change—again, change being the nature of the world in which we live. Most importantly, managers and staff will need time and support to adapt to the many system enhancements recommended in this Strategic Plan, as they come on stream under thoughtful but strong change management processes. Many will be challenged by new ways of working together between mental health and SUA, but based on the feedback we have received, we feel strongly that this is the way forward, and that it's been a long time coming.

All of these Strategic Directions call for significant attention to the “**system supports**” that are needed to shore up services and make them optimally effective. This will take some additional investment, but it's not all about new resources. It's also about a new **governance model** to consolidate provincially-focused organizations to optimally leverage their collective strengths and ensure a much stronger continuum of integrated SUA/MH services across the province. The other “Enabling Supports”—**evidence and knowledge translation; surveillance and performance measurement**, and **engagement and change management** are also all critical supports for achievement of the Vision and the Goals or the Strategy. These constitute critically important aspects of the many recommendations above.

In closing, it will be important not to go too fast, but at the same time, to always go forward with confidence and a sense of collaboration and partnership. Manitoba, and all Manitobans, deserve the best. There is a lot at stake, both economically, and in terms of the burden that that SUA/MH challenges are exacting among individuals, families and whole communities. This Strategic Plan offers a concrete way forward to improved mental wellness of all Manitobans.