

Evaluation of PHAC's Mental Health Activities

FINAL REPORT – JULY 2025

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List of Acronyms

CAMH	Centre for Addiction and Mental Health
CCDSS	Canadian Chronic Disease Surveillance System
CCDPHE	Centre for Chronic Disease Prevention and Health Equity
CIHR	Canadian Institutes of Health Research
CMHW	Centre for Mental Health and Wellbeing
CPAB	Communications and Public Affairs Branch
CSAR	Centre for Surveillance and Applied Research
DLI	Distress Line Investment
G&Cs	Grants and Contributions
HPCDPB	Health Promotion and Chronic Disease Prevention Branch
KDE	Knowledge Development and Exchange
KHP	Kids Help Phone
MHBC	Promoting Health Equity: Mental Health of Black Canadians Fund
MH COVID	Supporting the Mental Health of those Most Affected by the COVID-19 Pandemic
MHP-IF	Mental Health Promotion Innovation Fund
PHAC	Public Health Agency of Canada
PMHSIF	Positive Mental Health Surveillance Indicator Framework
PTSD	Posttraumatic Stress Disorder
PTSD COVID	Addressing post-traumatic stress disorder (PTSD) and trauma in those most affected by COVID–19

Executive summary

Background and evaluation scope

During the period covered by this evaluation, Canada's mental health landscape has been shaped by the COVID-19 pandemic, which intensified psychological distress, especially among youth, Indigenous communities, and equity-deserving groups, while straining public health resources. In response, the federal government committed \$100 million through Budget 2021 to support mental health promotion and prevention.

The Public Health Agency of Canada (PHAC) promotes the mental health of Canadians through a variety of activities including the following:

- providing funding to organizations who, in turn, work within communities to promote mental health and prevent suicide;
- conducting surveillance activities;
- acting as a convener and catalyst;
- leveraging the knowledge gained from the funded programs, surveillance, academia and other sources of knowledge; and
- sharing this information through a variety of forums.

This evaluation examines the alignment, impact, and efficiency of PHAC's mental health activities between April 2019 and December 2024 inclusively.

Findings

Alignment

The Public Health Agency of Canada's (PHAC) mental health activities were aligned with the Agency's role as a convener, funder, and knowledge mobilizer for health promotion and suicide prevention activities. PHAC's funding for the 9-8-8: Suicide Crisis Helpline was considered appropriate since it fits its role as a convener, as service delivery occurs through a network of local, regional and national crisis lines. Activities are also aligned with legislative commitments from the federal government and respond to emerging commitments.

While anyone can experience poor mental health and mental illness, some populations are disproportionately affected. As a result, PHAC has tailored programming to respond to the

needs of specific population groups facing higher rates of poor mental health, systemic barriers to positive mental health, and other known social determinants of health.

Promotion of mental health resources, including 9-8-8, was also targeted to higher-risk individuals and populations, and informed by surveillance of positive mental health and mental illness.

Impacts

PHAC's mental health activities have made documented impacts on the availability of mental health data and have improved awareness of the mental health resources available on the Canada.ca web site, including 9-8-8. PHAC's investments in mental health promotion through community organizations resulted in the development of, and improved access to new mental health resources. Based on available performance data and reporting, many participants in funded mental health promotion programs report having used these resources. Nearly all projects also reported improved health and protective factors among participants. Furthermore, through the Mental Health Promotion Innovation Fund (MHP-IF), phased funding has encouraged scaling of successful initiatives. There were limitations in available quantitative data across some grant and contribution (G&Cs) programs, as recipients were not required or not able to report on key indicators.

Efficiency

PHAC's activities for mental health address relevant issues like promoting mental health in priority populations and responding to emerging issues like COVID-19. However, PHAC faced challenges supporting a cohesive and consistent set of activities and objectives while responding to unplanned direction and demands, in part due to unpredictable challenges associated with the COVID-19 pandemic and post-pandemic recovery. Most internal interviewees perceived a lack of shared strategic direction for mental health activities across the Agency.

At the same time, PHAC made efforts to promote greater internal collaboration and enhanced information sharing across various work units involved in mental health activities. Additionally, the Knowledge Development and Exchange (KDE) hub and the Promoting Health Equity: Mental Health of Black Canadians Fund (MHBC) Knowledge Mobilization Hub "Amandla Olwazi", which is funded by PHAC, has facilitated knowledge exchange among funding recipients. Furthermore, by using existing relationships with third-party organizations and distributing funds through established programs, PHAC was able to quickly allocate significant funding to community organizations to support mental health during COVID-19. PHAC also made gained efficiency by leveraging the networks,

partnerships, and funding sources of recipient organizations to implement distress centre programming.

Recommendations

Recommendation 1: Consider developing a coherent strategic direction across all PHAC activities supporting mental health.

While PHAC's activities for mental health are generally aligned with emerging issues, they were often driven by external demands, particularly as the Agency addressed unprecedented challenges during the pandemic period. There was a perceived lack of a coherent strategy tying these activities together. This created challenges and contributed to a siloed or fragmented approach to addressing mental health across the Agency. Developing a coherent strategic direction that describes all PHAC mental health activities, including funding programs, surveillance, and communication would help clarify shared goals and priorities within the Agency and for external stakeholders.

Recommendation 2: Examine opportunities to improve the consistent collection and reporting of performance data across funding recipients for PHAC's mental health programs.

In some program areas, particularly those with shorter-term funding and lower-value grant funding, there was a lack of performance information from funding recipients on key shared performance indicators. This limits the ability of management to understand and communicate the shared impact of funded programs on overarching mental health priorities. Related to the first recommendation, it would be beneficial to examine opportunities to improve the consistency of performance data collection for funding recipients, such as establishing common indicators across PHAC-funded projects, where possible.

Management Response and Action Plan

Recommendation 1: Consider developing a coherent strategic direction across all PHAC activities supporting mental health.

Management response

Management agrees with the recommendation.

While PHAC's mental health activities have demonstrated alignment with emerging issues and other mental health commitments across the federal government, communicating a clear and coherent narrative for PHAC's role in mental health will help clarify shared goals and priorities for both internal and external stakeholders for greater transparency.

The Centre for Mental Health and Wellbeing (CMHW) will develop a placemat outlining PHAC's population mental health strategic directions, priorities, roles and responsibilities. This placemat will be used to communicate more clearly PHAC's role and priorities for mental health.

The placemat will be informed by ongoing activities such as CMHW's development of an internal paper entitled Mental Health Promotion - The Foundation of a Population Mental Health Approach, and the Centre for Surveillance and Applied Research's integrated mental health surveillance approach.

Action Plan	Deliverables	Expected Completion Date	Accountability	Resources
1.1 Development of a Placemat on PHAC's Population Mental Health Strategic Directions and Roles and Responsibilities.	Placemat with annex in the back highlighting the PHAC's Roles and Responsibilities	June 30, 2026	Director General, Centre for Mental Health and Wellbeing Vice President, Health Promotion and Chronic Disease Branch	To be completed within existing human and financial resources in CMHW.

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Recommendation 2: Examine opportunities to improve the consistent collection and reporting of performance data across funding recipients for PHAC’s mental health programs.

Management response

Management agrees with the recommendation, while recognizing certain limitations.

The collection and reporting of performance data across funding recipients for PHAC’s mental health programs enables management to understand and communicate the shared impact of funded programs on overarching mental health priorities.

PHAC’s mental health programs are diverse and include, for example:

- short term (<2 years) funding programs that are rapidly implemented, amidst resource and capacity constraints, in response to public health emergencies. Projects under such programs may be funded through grants which are unconditional. Projects funded through grants must meet certain eligibility requirements and do not need to meet any further conditions after they receive payment. Projects funded through contributions may be challenged to report on some outcomes indicators in this timeframe and may differ significantly in the data they do provide, given differences in scope of work among funded projects;
- funding programs focused on specific communities and/or populations, which may require specialized and culturally-safe indicators or reporting mechanisms; and
- long term (up to 10 years) funding programs focused on the development, adaptation, implementation, and evaluation of promising and innovative mental health promotion interventions. Projects funded under such programs are not expected to report on all outcomes indicators each year; longer term outcomes are expected at the end of the funding cycle.

This diversity adds complexity to the consistent collection and reporting of performance data across PHAC's mental health programs and shapes and informs the ways to respond to this recommendation.

Action Plan	Deliverables	Expected Completion Date	Accountability	Resources
2.1.1 Enhance sharing of Performance Measurement and Evaluation (PME) tools and resources across HPCDP programs, and new programs, focused on mental health and wellbeing including, but not limited to, Mental Health Promotion Innovation Fund (MHPIF), Preventing Family Violence, Youth Substance Use Prevention, and Suicide Prevention.	2.1.1 HPCDP Community of Practice on PME established by the Centre for Mental Health and Wellbeing (CMHW) to facilitate sharing of performance measurement best practices, tools, and resources among HPCDP programs and program officials focused on mental health and wellbeing. Associated deliverables include: • Terms of Reference formalizing the CoP's purpose, composition, and meeting frequency. • Initiation of Bi-Monthly CoP meetings, chaired and facilitated by CMHW	August 29, 2025 September 30, 2025	Director General, Centre for Mental Health and Wellbeing, Vice President, Health Promotion and Chronic Disease Branch	Existing resources in CMHW
2.1.2 Assess opportunities and feasibility of enhancing access to PME specialists across the Branch to support new and/or existing programs, and their funding recipients, in the collection and reporting of performance data. Note, this assessment will take place as part of the Branch HR and Financial stabilization exercise that is currently underway.	2.1.2 Report on options for enhancing consistency and access to PME specialist support for programs	March 31, 2026	Director General, Office of Strategic Directions, Vice President, Health Promotion and Chronic Disease Branch	

2.2 Establish common logic model for use across all of PHAC's Mental Health Promotion Programs to facilitate the consistent collection and reporting of performance data across programs and their funding recipients.	2.2.1 Mental Health Promotion Program – Common Logic Model	June 30, 2026	Director General, Centre for Mental Health and Wellbeing, Vice President, Health Promotion and Chronic Disease Branch	Existing resources in CMHW
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Context and description of PHAC's mental health activities

The evaluation covers a period of heightened national focus on mental health, shaped by the profound impacts of the COVID-19 pandemic and evolving federal commitments. Increased demands on the public health agency during this period resulted in reallocation and redeployment of existing Agency resources towards addressing the COVID-19 pandemic. The COVID-19 pandemic also exacerbated mental health challenges across the Canadian population, with evidence showing increased levels of anxiety, depression, and psychological distress, particularly among youth, Indigenous populations, and other equity-deserving groups.^{1,2}

In response, the federal government strengthened its role in mental health policy, including the creation of the Minister of Mental Health and Addictions in October 2021, with a mandate to develop and implement a comprehensive, evidence-based mental health strategy and to ensure timely, equitable access to services.³

This period also saw significant federal investments in mental health, with Budget 2021 committing up to \$100 million over three years for mental health promotion and mental illness prevention.⁴ Within this context, PHAC's mental health promotion and suicide prevention activities were implemented as part of broader efforts to strengthen population mental health in Canada.

PHAC promotes the mental health of Canadians through a variety of activities including the following:

- providing funding to organizations who in turn work within communities to promote mental health and prevent suicide;
- conducting surveillance activities;
- acting as a convenor and catalyst by leveraging the knowledge gained from the funded programs, surveillance, academia and other sources of knowledge; and,
- sharing this information through a variety of forums.

Through its Centre for Surveillance and Applied Research (CSAR), PHAC leads national public health surveillance for mental health, including positive mental health, suicide and self-harm, mental illness, and related risks and protective factors. PHAC reports national, provincial, and territorial data, when possible, on the following:

- mental illness, using administrative health records from the Canadian Chronic Disease Surveillance System (CCDSS) and through Statistics Canada's population-based health surveys;
- positive mental health and associated risks and protective factors, primarily through Statistics Canada's population-based health surveys; and
- suicide and self-harm, including suicide deaths, based on work with the Chief Coroner and Chief Medical Examiner Public Health Collaborative and National Vital Statistics Database, as well as other suicide-related behaviours like self-harm hospitalizations and emergency department visits, and suicidal ideation through Statistics Canada's population-based health surveys.

Through the Communications and Public Affairs Branch (CPAB), PHAC promotes awareness of positive mental health resources and initiatives to people in Canada through public communication activities, including marketing and advertising, media engagement, and digital communications on the Canada.ca website and social media.

Finally, through the Centre for Mental Health and Wellbeing (CMHW) and Centre for Chronic Disease Prevention and Health Equity (CCDPHE), PHAC supports and funds programming aimed at mental health promotion, mental illness prevention, and suicide prevention. Through long-term funding like the Mental Health Promotion Innovation Fund (MHP-IF), PHAC helps build evidence and share knowledge about what works, why it works, and for whom, in delivering community-based mental health promotion programming through population health approaches, which aim to improve the health of the entire population and reduce health inequities among population groups. PHAC also supported time-limited, issue-specific programs to address the mental health impacts of the COVID-19 pandemic, and the mental health of Black Canadians. The Agency provides funding to support suicide prevention and crisis services, including the 9-8-8 network and Kids Help Phone. Furthermore, PHAC provides policy leadership, information, and activity coordination through frameworks and action plans, such as the National Suicide Prevention Action Plan and the Federal Framework on Posttraumatic Stress Disorder (PTSD).

Evaluation scope and approach

The evaluation covers PHAC's mental health promotion and suicide prevention activities, including seven PHAC G&Cs programs, as shown in [Appendix A](#), the National Suicide Prevention Action Plan, the Federal Framework on PTSD, and PHAC's mental health

surveillance activities from April 2019 to December 2024. It did not assess the following activities:

- The Youth Mental Health Fund, which is Health Canada led and PHAC only has a small role;
- The Distress Line Equity Fund, due to unavailable results during the period in scope;
- The Youth Substance Use Prevention Program, which will be covered by the Canadian Drugs and Substances Strategy evaluation taking place in 2028-29; nor,
- Applied research on mental health.

The evaluation does not cover “Preventing and Addressing Family Violence: The Health Perspective” and “Preventing Gender-Based Violence: the Health Perspective”, as these have been the subject of their own recently completed program evaluations.

Evaluation questions

The evaluation answers three key questions:

- **Alignment:** Is PHAC investing in areas that are consistent with a federal public health mandate, and adequately responsive to diverse mental health needs across population groups?
- **Impact:** What have been the impacts of PHAC’s mental health activities?
- **Efficiency:** How efficient is PHAC’s approach to its mental health activities?

The evaluation draws on multiple lines of evidence, as described in [Appendix A](#).

Findings

Alignment

Key takeaways: PHAC’s mental health activities were aligned with the Agency’s role as a convener, funder, and knowledge mobilizer for health promotion. Activities were also aligned with legislative commitments from the Government of Canada and responded to emerging commitments.

According to the 2006 *Public Health Agency of Canada Act*, PHAC was established to implement public health measures, including health protection, promotion, and surveillance, as well as emergency response.⁵ For mental health, PHAC leads federal health promotion and prevention activities related to mental illness, positive mental health,

and suicide. It engages with key partners, including provincial and territorial partners, Indigenous communities, and other stakeholders, to advance national mental health priorities and suicide prevention efforts. The federal government also coordinates national data collection and surveillance of mental illness, suicide, self-harm, and positive mental health, and it also promotes applied health research.

During the period covered by this evaluation, PHAC funded upstream mental health prevention and promotion initiatives through seven grants and contributions programs, such as the following:

- the Mental Health Promotion Innovation Fund (MHP-IF);
- the Promoting Health Equity: Mental Health of Black Canadians Fund (MHBC);
- two COVID mental health programs: the Addressing Post-Traumatic Stress Disorder and Trauma in those Most Affected by COVID-19 Fund (PTSD COVID) and the Supporting the Mental Health of Those Most Affected by COVID-19 Fund (MH COVID);
- Two surge-capacity crisis line funding programs: the Distress Line Investment (DLI) and funding for Kids Help Phone (KHP); and,
- The 9-8-8 Suicide Crisis Helpline (9-8-8).

These initiatives were aligned with PHAC's focus on preventing mental illness and promoting positive mental health. The MH COVID and PTSD COVID funding streams have now ended.

Short-term and time-limited COVID-19 distress line funding through the Distress Line Investment (DLI) was provided during the pandemic. This funding stream has now ended. Organizations that joined the 9-8-8 Network now receive funding through the Centre for Addiction and Mental Health (CAMH), who has a contribution agreement with PHAC for the coordination and delivery of 9-8-8.

Most internal and external interviewees agreed that federal funding for suicide prevention through Talk Suicide/9-8-8 and COVID Distress Centre Funding was appropriate, even though provinces and territories are typically responsible for providing mental health services. These interviewees saw PHAC's activities in this area as aligned with its role as a convener, since service delivery still occurs at the local level. Talk Suicide/9-8-8 leveraged a network of local distress centres and provincial services to offer nationwide access through a single phone number, aiming to promote consistent access to suicide prevention support across Canada. Furthermore, PHAC was identified as the designated entity for reporting to Canadians on the progress of suicide prevention every two years,

under the *Federal Framework For Suicide Prevention Act*, making it a logical choice to manage the Canada Suicide Prevention Service funding agreement. PHAC also has well-established networks and a public health role in suicide prevention that could be leveraged for a successful implementation.

In the past five years, several of PHAC's activities were aligned with a parliamentary direction, or conducted in response to unanticipated crises. For example, PHAC's work on PTSD COVID was aligned with legislative commitments under the *Federal Framework on Post-traumatic Stress Disorder Act*, and the establishment of a three-digit suicide prevention number (9-8-8) was in response to a parliamentary motion. Similarly, MHBC was developed in response to a Budget 2018, where PHAC received \$10 million over five years to develop more culturally responsive knowledge, capacity and programs to address mental health and its determinants for Black Canadians.⁶ PHAC also implemented short-term funding initiatives like PTSD COVID and DLI to address increased demands for mental health resources during the COVID-19 pandemic.

Alignment across the Health Portfolio

Across the Health Portfolio, PHAC, Health Canada, and the Canadian Institutes for Health Research (CIHR) all undertake work to advance the federal government's mental health priorities. PHAC funds activities related to mental health promotion and suicide prevention, and conducts public health surveillance. Health Canada directs funding to the provinces and territories through transfer payments to provide health services to their populations. Examples of these transfer payments include the Canada Health Transfer and the Youth Mental Health Fund. Health Canada also works with provinces and territories to regulate pharmaceutical drugs. CIHR funds academic research on mental health and illness, including research initiatives like rapid research syntheses on COVID-19 and Mental Health and on Post-Traumatic Stress Injuries among public safety personnel, as well as providing grants for evaluating the Integrated Youth Services Network. In general, PHAC funds applied and intervention-based research conducted by community organizations, including implementation research, while CIHR tends to fund basic research conducted in academic settings.

Some internal interviewees highlighted that it has been occasionally difficult to clearly delineate the boundaries in work between PHAC and Health Canada. When things were unclear, the two organizations collaborated in order to clarify roles to advance their work. For example, PHAC collaborated with Health Canada on the development of the Youth Mental Health Fund.

Addressing differences in mental health needs across various population groups in Canada

Key Takeaways: PHAC has appropriately tailored programming to respond to the needs of specific population groups disproportionately affected by poor mental health, or social determinants that may present barriers for positive mental health, act as fundamental causes of mental illness, or are barriers for accessing services due to stigma or discrimination. Promotion of mental health resources, including 9-8-8, has been targeted to higher risk individuals and populations and informed by surveillance of positive mental health and mental illness.

Evidence from PHAC surveillance, relevant literature, and public opinion research demonstrates disparities in mental health outcomes across various groups.

- **Positive Mental Health:** Evidence from PHAC's surveillance of positive mental health and public opinion research indicates that young adults, Indigenous persons, and sexual minorities are all less likely to report positive mental health outcomes relative to the general population in Canada.^{7,8}
- **Mental Illness:** Evidence from literature and PHAC surveillance of mental illness shows that females are more likely than males to report mood and anxiety disorders.^{9, 10, 11}
- **Suicide:** Evidence from literature and PHAC surveillance of suicide shows that females are twice as likely as males to report suicidal ideation; however, suicide mortality is three times higher for males than females. Furthermore, Canadian research demonstrates that suicide rates among First Nations people, Inuit and Métis in Canada are significantly higher than among the overall Canadian population.¹²
- **PTSD:** According to the Federal Framework on Post-traumatic Stress Disorder, certain occupational groups are at higher risk for PTSD, including Canadian Armed Forces members and Veterans, first responders, health care providers, and Indigenous people who work in high-stress occupations. Many people are also at risk for PTSD as a result of experiences outside of an occupational setting, including survivors of sexual or interpersonal violence, refugees, 2SLGBTQI+ people, Indigenous people, people experiencing homelessness, and survivors of major accidents or disasters.¹³
- **Social Determinants of Health:** Evidence from PHAC reports outlines the complex interplay between the social determinants of health and the broader systems and

policies that influence mental health, resulting in a greater risk of poor mental health among some populations. The 2020 PHAC report “Social determinants and inequities in health for Black Canadians: a snapshot” and the 2024 report “Inequalities in mental health, well-being and wellness in Canada” both describe risk factors, including socio-economic conditions; experiences of racism, homophobia, xenophobia or other discrimination; socio-cultural and community connection; and access to services as key factors influencing mental health.^{14,15} These two reports illustrate that certain groups, such as Black people in Canada, racialized persons, women, and 2SLGBTQI+ individuals, are overrepresented in experiencing some of these negative social determinants of health that may result in greater risk for poor mental health outcomes.

Tailoring projects to respond to needs across population groups

During the evaluation period, several of PHAC’s G&Cs programs were tailored to respond to needs of specific sub-populations within Canada:

- **MHBC** is designed to respond to the unique mental health challenges faced by Black communities in Canada. The program was co-developed with a multi-disciplinary group of Black experts. The Mental Health of Black Canadians working group plays an integral role in recommending projects for funding, providing strategic guidance on capacity building, and strengthening evidence.
- **PTSD COVID** funding targets occupational groups highly affected by occupational exposure to traumatic events during the COVID-19 pandemic, including first responders, educators, and public safety personnel.
- **Kids Help Phone** funding supports mental health, counselling, and crisis support for young people.

The solicitation process for G&Cs programs includes equity considerations by requiring applicants to specify which equity-seeking groups would be targeted by their programming. In addition, recipients of MHP-IF, MHBC, and MH COVID funding were asked to report on participation of priority sub-populations.

- **MHP-IF**: applicants were required to demonstrate how equity-seeking groups would be targeted through interventions. By Phase 2, Year 1 (2022-2023), all projects implemented equitable strategies for gender and cultural sensitivities, 14 out of 15 were adapted to local, political, and economic contexts, and 13 out of 15 targeted the involvement of people who experience disadvantages.

- **MH COVID:** targeted solicitation processes were conducted to address unmet needs in specific populations, including Black Canadians, children and caregivers, First Nations and Métis communities.
- **MHBC:** a specific funding stream was in place in 2020-23 for 2SLGBTQI+ Black Canadians.
- **9-8-8: Suicide Crisis Helpline:** this helpline aims to provide access across Canada to suicide prevention support. Indigenous Services Canada has a dedicated funding program for the Hope for Wellness Helpline, a key partner in the 9-8-8 network, which specifically supports Indigenous communities. Additionally, Kids Help Phone (KHP) is part of a sub-network within 9-8-8 that handles calls from youth.

The evaluation found that PHAC surveillance informed the development of PHAC's mental health programming. In 2020, PHAC prepared "Social determinants and inequities in health for Black Canadians: A Snapshot" in response to a lack of Canadian data on the mental health of Black populations. The report analyzes and summarizes data on social determinants like racism and systemic discrimination that result in health inequalities for Canadian Black communities, including mental health.¹⁶ Furthermore, some internal interviewees indicated that CSAR surveillance tools were referenced in the identification of priority populations for tailored G&Cs funding.

Federal mental health marketing and advertising efforts led by CPAB are evidence based. For example, CPAB has used demographic factors, psychographic factors, behavioural factors, and geographic factors to target its digital campaigns. Furthermore, tailored ads were developed for specific populations, informed by national focus groups with target populations across Canada, such as parents of school-aged children, youth and young adults, Indigenous peoples, members of the 2SLGBTQI+ community, men aged 35 and older, and racialized populations. This included tailored advertisements promoting awareness of 9-8-8.

Effectiveness

Key Takeaways: PHAC's mental health activities made documented impacts on availability of mental health data, and improved awareness of available resources, including on the Canada.ca website and through the 9-8-8 network. PHAC's investments in mental health promotion through community organizations has resulted in the development of, and improved access to new mental health resources. Available performance data shows that many participants in funded mental health promotion programs reported using these resources. Nearly all projects that measured changes in health behaviours and protective factors among their participants reported improvements

resulting from their activities. Furthermore, phased funding provided through the MHP-IF supported scaling of successful initiatives.

Availability of mental health data

PHAC's activities resulted in improved data availability related to mental health, including on positive mental health, suicide and self-harm, and mental illness. Data was communicated through products like data tools, infographics, and data blogs, in addition to publications in peer-reviewed journals.

Surveillance of mental health

CSAR funded, collaborated on, and developed various knowledge products to increase the availability of mental health data in Canada. For example, PHAC's surveillance of positive mental health, which is based on the Positive Mental Health Surveillance Indicator Framework (PMHSIF), tracks outcomes like self-rated mental health, happiness, life satisfaction, and social well-being, thus providing data that complements illness and hospitalization measures. Experts cited this framework as a model for other countries, and it has received high user satisfaction ratings. According to performance data, 96% of web users found the PMHSIF framework satisfactory. As of Q3 of 2024-2025, PHAC's peer-reviewed publications that focused on positive mental health were cited nearly 200 times.

PHAC collaborated with partners to improve surveillance of suicide, self-harm, and suicide-related behaviours, and improve access to prevention services. For example, in 2024, PHAC and provincial and territorial Chief Coroners and Chief Medical Examiners developed common data elements to pilot for suicide death investigations. PHAC also updated suicide, self-harm, and suicide-related behaviours data on Health Infobase through the Suicide Surveillance Indicator Framework website and the new Suicide and Self-Harm Dashboard. Furthermore, PHAC is supporting CAMH in developing a 9-8-8 data and monitoring strategy, with a governance committee established to enhance data quality, use, and accessibility. Between 2019 and 2025, CSAR published 20 articles on suicide and self-harm related surveillance, and 16 articles on positive mental health surveillance.

The CCDSS is a collaborative network of provincial and territorial surveillance systems supported by PHAC. It collects data on all residents eligible for provincial or territorial health insurance. Currently, the CCDSS reports on indicators for schizophrenia, mood and anxiety disorders, as well as overall mental illness and alcohol/ drug-induced disorders (health services use and prevalence where possible). Additionally, routine surveillance of

mood and anxiety disorders is conducted using the Canadian Community Health Survey, and reported through PHAC's Health of People in Canada dashboard.

Surveillance responding to COVID-19 and PTSD

During the COVID-19 pandemic, PHAC collaborated with other governmental departments and provinces and territories to collect data on COVID-related mental health topics.

Examples include the following:

- The Survey on Mental Health and Stressful Events (SMHSE) collected data on experiences of potentially psychologically traumatic events, symptoms and diagnoses of PTSD, diagnoses of mood and anxiety disorders, as well as other mental health topics, including use of mental health services and barriers to care. SMHSE data has been published as a data blog on the Health Infobase.
- The Survey on COVID-19 and Mental Health (SCMH) collected data on positive mental health, suicidal ideation, symptoms of anxiety, depression, and PTSD, and other mental health topics during the pandemic. SCMh data has been published on Health Infobase, Canada.ca, and in peer-reviewed publications.

In response to the Federal Framework on PTSD priority area of “improved tracking of the rate of PTSD and its associated economic and social costs”, PHAC collaborated with other organizations to collect and analyze data. For example, CSAR collaborated with the Association of Workers' Compensation Boards of Canada making use of the National Work Injury Statistics Program to examine PTSD-related lost time claims over time. Subject matter experts identified this approach as a promising practice for monitoring trends of PTSD-related costs in the future. PHAC also collaborated with the Institute for Clinical Evaluative Sciences to use linked electronic medical record primary care data to estimate PTSD-related health care costs in Ontario.

Funded projects' contribution to increasing availability of data

The seven G&Cs programs did not specifically aim to increase availability of mental health data as an outcome. Nonetheless, some projects funded through MHBC and the MH COVID fund reported some progress in this area. For example:

- The Amandla Olwazi Knowledge Mobilization Network, funded through the MHBC Fund, produced a literature review that identified a lack of race-based data as a barrier to culturally-appropriate health services for Black Canadians.¹⁷
- The Mental Health of Black Communities in the National Capital Region project, funded through the MHBC Fund, conducted a survey examining the socio-cultural

determinants of mental health, the results of which were reported in 10 published research articles.

- The MH COVID stream funded the Community-Based Research Centre (CBRC) to analyze 2SLGBTQI+ COVID-19 survey data, resulting in eight research data reports and policy briefs on mental health impacts.

Canadians’ access to mental health information and resources

Promoting Government of Canada mental health resources

CPAB promotes awareness and access to resources for mental health and wellness by providing strategic communications support for these activities in the regions, as well as media relations, media monitoring, and ministerial services. Between April 2019 and March 2024, CPAB prepared over 100 news releases and statements related to mental health. CPAB also promoted mental health resources through web and social media content, including a Winter 2024 9-8-8 digital advertising campaign achieving 62 million impressions, 11 million video ad completions, and over 252,000 clicks to mental health information on Canada.ca between February 12 and March 31, 2024.

CSAR surveillance and information products

PHAC shares surveillance data and information via Canada.ca and the Health Infobase platform. Products include the PMHSIF, the Suicide Surveillance Indicator Framework (SSIF), a dashboard on mental health, the CCDSS data tool, and a dashboard on suicide, and self-harm. As described in Table 1, these products were cumulatively accessed over 10,000 times in 2023-2024 and over 20,000 times in 2024-2025.

Table 1: Access to CSAR surveillance products on Canada.caⁱ

Surveillance Product	2023-2024	2024-2025
PMHSIF	8,835 sessions	6,567 sessions
SSIF	2,218 sessions	2,853 sessions
Suicide and Self-Harm Dashboard	N/A	8,950 sessions

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Surveillance Product	2023-2024	2024-2025
Mental Health Dashboard	N/A	4,490 sessions
Note: 2024-2025 data is up to December 2024		

CSAR’s information products specific to the COVID-19 pandemic helped increase the accessibility and usability of mental health surveillance to the general public. Topics included “Symptoms of anxiety and depression during the COVID-19 pandemic”, “Symptoms of PTSD during the COVID-19 pandemic”, “Mental health during the second wave of the COVID-19 pandemic in Canada”, and “Long-term neuropsychiatric symptoms of COVID-19 among adults.”^{18, 19, 20, 21} Through the Pan-Canadian Health Inequalities Reporting Initiative, PHAC also developed an infographic on “Inequalities in perceived mental health in Canada”, describing social determinants associated with lower self-reported mental health. This infographic was the second-most downloaded mental health content on the Canada.ca website, downloaded over 1,300 times between July 2021 and October 2024. The Agency also developed COVID-specific data tools like the Map of Canadian Mental Health during the COVID-19 Pandemic, which was accessed over 9,000 times, and the Canadian Risk Factor Atlas, which included three MH-related indicators.^{22,23}

CPAB’s Digital Communications has updated the mental health web content on Canada.ca by improving navigation to mental health, suicide prevention, and 9-8-8 resources on Canada.ca, and through ongoing removal, consolidation, or rewriting of outdated content to ensure resources are accurate and up-to-date. Usability testing confirmed that the digital content on mental health is currently well organized and intuitive for users to navigate.

Access to resources through PHAC-funded organizations

Annual reports from the four G&Cs programs that fund community organizations for innovation and services related to mental health (MHP-IF, MH COVID, PTSD COVID, MHBC) show that the projects generated over 2,000 knowledge products and events, accessed by hundreds of thousands of clients, at hundreds of sites across Canada between 2020-2021 and 2023-2024. Programs also targeted mental health professionals through their activities: the MH COVID and PTSD COVID programs reached over 50,000 professionals each in 2023-2024, while MHBC reached over 15,500 staff and professionals between 2018-2019 and 2023-2024, and MHP-IF reached over 11,000 between 2020-2021 and 2023-2024. For additional results, please refer to [Appendix B](#).

Funded projects improved access to resources by producing a variety of webinars, educational tools, and resources, as well as by directly delivering intervention programs for people living in Canada. Examples of access to resources include the following:

- A MH COVID program in Quebec provided 63,628 people from minority groups with mental health services. The Community Health and Social Services Network (CHSSN) supported 46 projects, establishing a community of practice, training activities, knowledge exchange sessions, workshops, and conferences.
- To support access to mental health programming for youth, “Y Mind” and “Mind Medicine”, funded by MH COVID, trained 1,123 YMCA staff in Mental Health First Aid, delivered Y Mind programming to 2,035 participants, and Mind Medicine programming to 117 participants in 10 Indigenous communities.
- The Beyond Silence m-health app, funded by PTSD COVID, was accessible to 33,317 health care workers across eight organizations, with over 120 health care workers trained to provide peer support via the app. By the final year of the project, the app was downloaded by 1,148 health care workers.
- The PSP training project, funded by PTSD COVID, delivered interventions to support the mental health of Canadian public safety personnel, with high satisfaction and extensive use of developed knowledge products. It was accessed by over 75,000 individuals.

Access to suicide prevention crisis services

Talk Suicide Canada enabled people in Canada to access crisis support through a network of participating distress centres by dialing a national phone number. In November 2023, this evolved to the three-digit phone number, 9-8-8, which offers suicide prevention support by voice and text, 24/7, in English and French. PHAC provides funding support to CAMH, the coordinator of 9-8-8, which collaborates with approximately 40 partners across its network.^{24, 25}

The Canada Suicide Prevention Service and Talk Suicide Canada answered between 71,000 and 88,000 calls and texts each year between 2020-2021 and 2022-2023, and over 300,000 calls and texts in the first year after the launch of 9-8-8 in 2023-2024. People in Canada connected with suicide prevention support in a timely manner, as the average wait time for 9-8-8 calls between November 30, 2023 and March 31, 2024 was 44.25 seconds, and the average wait time for texts was 1 minute and 34 seconds. An evaluation of 9-8-8 conducted by an external evaluation consultant, and commissioned by the program, found that there were technological shortcomings limiting accessibility for some linguistic and cultural communities, and individuals with disabilities, such as those who are

deaf or have visual impairments. The review also found that organizations representing people with disabilities would like to be more involved in 9-8-8.

Kids Help Phone (KHP) answered an average of approximately 320,000 calls, chats, and texts between 2020-2021 and 2022-2023. The average wait time in 2022-2023 was approximately 5 minutes for both text and phone channels. KHP wait times have increased since 2020-2021 from less than 1 minute for texts and 4.5 minutes for calls to just over 5 minutes for calls and approximately 5.6 minutes for texts. However, wait times have decreased significantly compared to pre-COVID levels of approximately 30 minutes, despite a 137% increase in call volume. This observed decrease in wait times is due in part to PHAC's financial support. KHP developed a safety plan with 51,326 young people at imminent risk, but did not require immediate support from emergency services. When risk was too high to de-escalate through safety planning, KHP conducted 12,021 emergency service referrals. For more information, please refer to [Appendix B](#).

Use of evidence and knowledge products on mental health

Through the MHP-IF and MHBC programs, and through short-term funding associated with COVID-19 via MH COVID and PTSD COVID, participants, experts, and decision makers used mental health promotion knowledge products to help improve their own decision making around mental health, and to improve supports available for people living in Canada.

- **MHP-IF:** About 25% of projects reported quantitatively on the use of health promotion evidence between 2020-2021 to 2022-2023. Among those projects that reported, about 97-98% of surveyed participants reported that they were using health promotion evidence. In addition, in 2023-2024, 86% of projects provided concrete examples, through qualitative reporting, of how they used MHP-IF project-funded evidence to improve programs, policies, and practices. For example, based on influence from the results of the Cedar Path project led by The Pas Family Resource Centre, two school divisions in Manitoba began awarding credits for land-based studies. Similarly, The UBC "Agenda Gap" program supported the BC Ministry of Health's evidence brief on how to engage youth in policy decision making.
- **PTSD COVID:** In 2022-2023, about 37% of projects reported on the use of health promotion evidence. Of those participants surveyed, 88% reported that they had used that evidence.

- **MH COVID:** In 2023-2024, 81% of participants surveyed had used data from MH COVID projects, a slight increase compared to 79% in 2022-2023.

Performance data on the use of mental health evidence and knowledge products was limited, as many projects were not required to report on this indicator. MHBC projects were asked to report on whether the funded projects had documented lessons learned from their interventions; however, these results were not available.

Annual and final project reports further illustrate the ways that health promotion evidence generated from their activities was used by program participants to improve their mental health, and by decision makers to inform policy and practice. For example:

- Through the MH COVID funding stream, projects developed evidence and knowledge products that were used to build the capacity of health care service providers, educators, coaches, and peers to improve the mental health of others. Knowledge products included training and resources to help identify and mitigate mental health issues, implement social prescribing practices to connect people with community services, and facilitate discussions about mental health.
- PTSD COVID projects developed tools, courses, and apps to support mental health and resilience among frontline workers during COVID-19. These resources were used to enhance skills in recognizing mental illness, promoting wellness, and accessing support. For example, a funding recipient at the Centre for Addiction and Mental Health adapted the "Resilient Minds" tool for Indigenous and francophone firefighters, and survey data from March 2024 indicated that 86% of those participants planned to use the information and skills they had learned from this tool.
- In the most recent fiscal year, which was phase 2, of year 2, MHP-IF funded project reports included 29 examples of influence on policy, programming, and practice: ranging from evidence discussed in key policy and practice forums that were cited or referenced, as well as informing practice, policy, or program decisions and leading to the implementation or adaptation of an intervention, policy, or program outside of funding. For example, the HORS-PISTE program was embedded into Quebec's mental health action plan for 2022 to 2026.²⁶

Improved protective factors and environments to support positive mental health

There are a variety of individual and environmental factors that can protect an individual's mental health. Individual protective factors include examples like eating well and staying physically active, while environmental protective factors can include living in a safe community, having healthy and supportive relationships, and living in adequate housing, among others.²⁷

Many of the projects funded through PHAC's mental health activities aimed to improve these factors and supports. Although it was limited for some years and for some programs, available performance data showed improvements for participants in MHP-IF and MHBC programming: other G&Cs programs like MH COVID and PTSD COVID did not collect information on this indicator. See [Appendix B](#) for more information.

- **MHP-IF:** In 2023-2024, 59% of surveyed participants reported improved protective factors because of the programming. This was an increase compared to previous years.
- **MHBC:** Approximately 2 out of 3 of surveyed participants reported improved protective factors, with results fluctuating between 56% and 70% of respondents reporting that their social environments were improved to support ongoing healthy behaviours.

Reporting from funding recipients noted that improved protective factors reported by participants included having a safe space to share feelings, improved relationships, and improved social networks via the various funded projects. For example:

- 65% of participants indicated that they felt comfortable expressing their feelings and opinions during sessions held as part of the Aspire for Higher Youth Mental Wellness project (MHBC), demonstrating a direct link between providing a safe space and fostering positive mental health.
- Participants of the Canadian Red Cross's Friendly Calls program, funded under MH COVID, felt less lonely (71%) and safer (86%) knowing there were personnel reaching out.
- 13% of youth in the MHP-IF funded Families in TRANSititions (FIT) program reported improved relationships with parents, caregivers, and peers and 29% of parents and caregivers reported improved relationships with children and family members.

- Nearly 9 in 10 (89%) participants in the Mind your Food program (MHP-IF) reported improvements in at least one protective factor for mental health, such as developing a wider support network.

Scaling of effective initiatives

The MHP-IF program supports successfully tested population health interventions to benefit more people and to foster sustainable policy and program development across diverse populations and communities, also referred to as “scaling”. Scaling could include the number of people reached, expanding or adapting to new sites and new sub-populations, influencing policy to support systems change, and deepening relationships to achieve a system-wide impact for project sustainability. This outcome only applied to MHP-IF funding recipients, as other programs were shorter term.

The MHP-IF provides up to 9 years of funding to projects using a gated funding model that supports scaling projects from proof of concept to expanded scope in partnership with other organizations. Recipients were required to demonstrate a potential for scaling in their funding applications in both phase one and phase two solicitations, and to report on progress towards sustainability and scaling in their annual reports.

Factors such as an expanding presence, multi-sectoral partnerships, and diversified funding streams help increase scale. Results from performance data show progress in these factors among recipients:

- An increasing proportion of MHP-IF projects had sites in more than three provinces and territories, from 25% in 2020-2021 to 47% in 2023-2024.
- Similarly, an increasing proportion of MPH-IF projects report leveraging funds from other sources, from 25% in 2020-2021 to 53% in 2023-2024.
- Nearly all MHP-IF projects engage in multi-sectoral collaborations, including approximately 90% of projects from 2020-2021 to 2022-2023, and 100% of projects in 2023-2024.

Improved health behaviours related to positive mental health

Quantitative results were available for MHP-IF, MH COVID, MHBC, and PTSD COVID funded projects. Performance data demonstrates that most projects reported improved health behaviours as a result of participation in the respective programs. However, quantitative performance data was limited, as notable proportions of projects did not provide results for these indicators.

- **PTSD COVID:** Between 35% and 57% of funded projects provided data on improvements in health behaviours. Given the time-limited nature of the projects and the various types of interventions funded, not all projects were required to report on this indicator. All of the projects that provided data (100%) reported improved health behaviours at the end of the funding period. Among participants surveyed, nearly 80% of individuals reported improved health behaviours in 2022-2023, falling to just over 60% in 2023-2024.
- **MHBC:** According to available data, between 2020-2021 and 2023-2024, 64% to 83% of participants surveyed by funded projects demonstrated skills and abilities to support healthy behaviour, and 63% to 86% reported improved health status.
- **MHP-IF:** All projects that provided data reported increased positive behaviour change. Among participants surveyed, the proportion of those reporting improved health behaviours increased from 64% to 79%. The proportion of projects reporting changes qualitatively was 80% at the end of phase one, and 86% at the end of phase two (phase 2, year 3).
- **MH COVID:** All projects providing data reported increased positive behaviour change. Given the time-limited nature of the projects and the various types of interventions funded, not all projects were required to report on this indicator. The proportion of projects reporting was 27% in 2022-2023 and 37% in 2023-2024. The proportion of individuals reporting behaviour change among those surveyed was about 80% for both years that data was available.

For more data on improved knowledge and skills as a result of PHAC-funded programming, please see Table 9 in [Appendix B](#).

Some examples of improved health behaviours resulting from funded projects include an improved ability to recognize mental illness, reduced anxiety, and improved coping skills. For example:

- After completing the Canadian Teachers' Federation 'Educator Wellbeing' Program, funded by PTSD COVID, a notable proportion of participants reported increased proficiency in recognizing signs of compassion fatigue (58%), recognizing signs of burnout (48%), signs of trauma (33%), and knowledge of how to increase resilience (31%).
- After completing the "Y Mind" program, funded by MH COVID, 85% of participants reported improved healthy coping skills, and 84% reported an increased

understanding of anxiety. These numbers were even higher among younger adults aged 18 to 30 who participated in “Y Mind Youth”, at 95% and 91%, respectively.

- The ArTeMo Project, funded by MHBC and led by the Council for the Advancement of African Canadians (Africa Centre), reported that 96% of participants improved their skills. Feedback showed they got better at self-care, expressing themselves, and handling tough emotions.
- Adolescents participating in HORS-PISTE, funded by MHP-IF, reported significant reductions in generalized anxiety and social phobia after completing the program. Participants also showed more tolerance of uncertainty, a positive attitude towards problems, felt less influence from anxiety in their daily lives, and showed increased self-efficacy following the workshops.²⁸

PHAC’s advertising efforts also achieved measurable improvements in help-seeking intentions among people in Canada. For example, evidence from CPAB-led federal advertising post-campaign evaluations of the “Out of Frame” advertising campaign, which ran in February and March 2024, found notable increases in the proportion of surveyed individuals who indicated that they were likely to consider calling 9-8-8, at 52% post campaign vs. 45% pre-campaign, or texting a helpline at 45% post campaign vs. 40% pre-campaign, if in need for a suicide-related concern.²⁹

Despite this, overall unaided awareness of the 9-8-8 helpline remains low. In March 2024, a survey conducted by PCO found that 16% of Canadians were aware of 9-8-8 and in January 2025 this dropped to 14%. In addition, CAMH commissioned Environics Research to conduct a survey with people living in Canada in summer 2024. This survey found that unaided awareness of 9-8-8 was at 4% with aided awareness (both name and number) at 34%. Stakeholders consulted as part of the 9-8-8 evaluation conducted by an external consultant and commissioned by the program also reported that public awareness of 9-8-8 remained relatively low in much of Canada, including among health professionals, educators, and first responders.

MHP-IF projects also provided many examples of improved knowledge resulting from their activities, ranging from a better understanding of client mental health needs, to better personal knowledge on how to manage mental health. For example:

- All respondents from the STRONG project either agreed or strongly agreed that their understanding of newcomer mental health needs and well-being increased after attending the session and 90% of the respondents either agreed or strongly

agreed that the information learned would help them to integrate new teaching practices.

- 84% of respondents who participated in the “Nurturing the Seed” project self-assessed their knowledge of mental health promotion as “moderately high” or “high”, compared to 44% in the pre-test.

Additionally, suicide prevention and mental health crisis phone lines generated documented improvements in caller well-being. According to a 2021 evaluation of the Canadian Suicide Prevention Service, almost two-thirds (65%) of callers surveyed said that they had figured out possible ways of coping during the session, and almost half had positive changes in their emotions. Follow-up surveys conducted in 2022-2023 from KHP callers showed that 6% of callers surveyed would have gone to the emergency room if they had not reached out to KHP. Furthermore, most (81%) said they felt less upset after their conversation with KHP, and felt more hopeful and more able to face challenges in their life (64%).

Efficiency

Key Takeaways: While PHAC’s mental health activities were aligned with emerging issues, there may be opportunities to enhance efficiency by clearly communicating a shared strategic direction for the Agency. Internal interviewees noted challenges in maintaining cohesive objectives, due to unpredictable COVID-19 pandemic demands, as well as unexpected and sometimes unfunded commitments emerging from outside the Agency.

Despite this, the Agency implemented good practices that ensured that activities were administered in an efficient manner. Efforts were made to enhance internal collaboration and information sharing across work units that deliver activities. Outside the Agency, knowledge mobilization networks facilitated knowledge exchange among Mental Health of Black Canadians Fund (MHBC), Supporting the Mental Health of those Most Affected by the COVID-19 Pandemic (MH COVID), and Mental Health Promotion Innovation Fund (MHP-IF) funding recipients. Furthermore, PHAC quickly allocated unanticipated funds to community organizations by leveraging existing networks and partnerships.

Strategic direction

Most internal interviewees reported a lack of a coherent strategy for PHAC’s mental health activities. There are some strategies and action plans that guide work in some areas, such as Federal Framework on PTSD and the National Suicide Prevention Action Plan; however, these plans were not associated with specific funding to support implementation

and do not cover the full range of PHAC's mental health activities. Furthermore, several internal interviewees noted that some mental health activities were implemented in response to government budget announcements, legislative commitments, or to rapidly address emerging needs. This was particularly apparent with respect to COVID-19 funding programs, including MH COVID, PTSD COVID, Kids Help Phone (KHP), and the Distress Line Investment (DLI), which were established or scaled up in response to the mental health crisis triggered by the pandemic.

Many internal interviewees identified a lack of coordination between the various units and centres involved in delivering mental health activities as a key challenge in the design and implementation of a coherent suite of mental health activities. Mental health activities at PHAC are delivered by three separate centres within the Health Promotion and Chronic Disease Branch: the Centre for Mental Health and Wellness (CMHW), the Centre for Surveillance and Applied Research (CSAR), and the Centre for Chronic Disease Prevention and Health Equity (CCDPHE). These activities are also supported by CPAB. Within the Health Promotion and Chronic Disease Prevention Branch (HPCDPB), G&Cs programs are split between two centres. Furthermore, each centre measures the performance of their activities with separate Performance Information Profiles. Each work unit operates with relative independence. Interviewees almost unanimously described the work undertaken by these units as largely "fragmented" and "siloed."

Most internal interviewees across all work units delivering mental health activities identified an opportunity to be more strategically proactive. Internal and external interviewees almost unanimously agreed that a clear expression of the Agency's priorities in the area of mental health could help align future funding with established priorities. For example, internal interviewees working on the PTSD Framework noted that, when resources became available to address PTSD among those most affected by COVID-19, PHAC was able to leverage the priorities established in the existing framework to align spending for the new program. This included providing contributions to community-based organizations, and funding to support the collection of survey data through CSAR and Statistics Canada. Several internal and external interviewees also noted that a coherent strategic plan would also help clearly demonstrate PHAC's key activities to provinces, territories, and other stakeholders in the mental health domain to help reduce potential for overlap.

Many countries have implemented national mental health and suicide prevention strategies to address the profound impact of mental illness on their populations. By 2020, 75% of World Health Organization member states had a mental health plan or policy.³⁰ Meanwhile, over 40 countries, including Canada, have a national suicide prevention strategy.³¹ Having multiple overlapping strategies was identified in two Australian studies

as a challenging factor resulting in confusion during implementation of national mental health and suicide prevention strategies.^{32, 33}

There are several international examples of mental health promotion-focused plans, notably, the Canadian strategy entitled *Changing Directions, Changing Lives*, developed in 2012. However, mental health strategies typically refer to a full continuum of care, including community-based and specialized services. Based on a synthesis of existing strategies commissioned to support this evaluation, a “whole of government” approach should be considered to effectively address mental health, mental illness, and suicide. Best practices in governance for this approach include involving senior staff from all implicated departments and ministries, ensuring accountabilities for each department involved, and including cyclical feedback structures to support ongoing collaboration.

Collaboration

Internal mechanisms to foster collaboration

The Agency implemented several organizational and process changes to coordinate internal on mental health across the participating centres. Management has also taken steps to streamline decision making. For example, the program and policy areas responsible for MH COVID, PTSD COVID, 9-8-8, KHP, and MHP-IF were combined into a single Centre for Mental Health and Wellness (CMHW) in 2022.

In addition, when implementing the MH COVID funding stream, the Trauma Support and Wellness Unit integrated their funding officer into the program and policy team, thus improving efficiency and communication. The CMHW brought together teams from the various units for regular meetings to align performance metrics, announcements, and communications with applicants and recipients. CSAR hired a senior policy analyst to coordinate mental health-related activities across the surveillance teams within CSAR and between surveillance, program, and policy functions within the larger branch. According to a few internal interviewees, this position was effective in achieving its intended goals; however, the position was temporary and ended in January 2025.

Some internal interviewees were uncertain about why MHBC was delivered by a different centre than other mental health promotion programs. They suggested that better engagement between MHBC and other mental health programs could be achieved by further integrating it with the CMHW. Program management highlighted that CCDPHE was chosen to house the MHBC in order to ensure preservation of the equity focus of the program, which was established prior to the creation of CMHW.

Supporting collaboration between funding recipients

The Knowledge Development and Exchange (KDE) Hub for MHP-IF and MH-COVID and the MHBC Knowledge Mobilization Hub “Amandla Olwazi” both contributed towards improved information sharing and collaboration between the funded projects.

The primary objectives of the KDE Hub, according to its contribution agreement, were to foster knowledge development and exchange between funded projects, to support the development and implementation of Population Health Intervention Research (PHIR) for each funded project, and to support knowledge translation and promotion of research findings on a broader scale. In addition to annual conferences bringing together funding recipients, such as the KDE Hub Annual Symposium and the MH COVID Capstone Event, the KDE Hub created resources and tools to support MHP-IF and MH COVID projects on topics such as project management for child and youth mental health, health equity frameworks, pandemic adaptations, and evaluation methods. They also launched projects to develop a cross-project pandemic adaptations study and accompanying resources. Similarly, the KDE Hub has led needs assessments and produced webinars that addressed the information needs of MHP-IF and MH COVID funded projects, aiming to enhance their capacity to deliver and measure results. Webinars featured Hub tools and resources, and topics included lessons learned from pandemic adaptations and other projects, various methodologies, evaluation, performance measurement, and project management. Feedback indicates high satisfaction with the KDE Hub’s activities, though some recipients reported only being engaged during the annual symposiums.

Similarly, the Amandla Olwazi project has two goals: “to gather, and synthesize knowledge through research, and community engagement, and develop Afrocentric principled knowledge mobilization products” and to engage “diverse Black community members and establish a strong collaborative partnership with groups to mobilize knowledge.”³⁴

Through the Amandla Olwazi project, TAIBU community health services generated summary knowledge products for the MHBC-funded projects, and hosted annual “ACT Now!” conferences attended by MHBC recipients, MH COVID recipients addressing black mental health, PHAC staff, as well as Black leaders, Black elders, Black youth, academics, advocates, students, volunteers, and mental health professionals from across Canada to discuss and gather knowledge around the multifaceted mental health issues affecting Black communities.

TAIBU Community Health Services created summary knowledge products for MHBC-funded projects and hosted annual “ACT Now!” conferences to discuss and gather

knowledge around Black mental health issues. As detailed in [Appendix C](#), the conference was attended by MHBC recipients, MH COVID recipients addressing mental health in Black communities, PHAC staff, and various Black leaders, community members, and professionals from across Canada.³⁵ Attendance for the annual conference has exceeded expectations and increased each year. Feedback from PHAC and external key informants show that the annual symposium was seen as an effective and beneficial platform for knowledge exchange between participants.

Additional information on the impacts of the hub and network is provided in [Appendix C](#).

PHAC has limited direct interaction with 9-8-8 partners due to restrictions of the further distribution model for their agreement with CAMH. However, PHAC used collaboration mechanisms to effectively work with partners and engage key participants during the design and implementation of 9-8-8. Building on this collaboration and leveraging existing mechanisms, PHAC engaged with partners, including federal government departments, provinces and territories, and other partners to inform the development of a National Suicide Prevention Action Plan.

Distribution of funding

Historically, the MHP-IF has been PHAC's primary funding mechanism for population mental health promotion interventions. When PHAC was assigned to manage up to \$100 million in new funding for mental health activities through the Supporting those Most Affected by COVID-19 Program, the Agency took steps to distribute the funding promptly to community-based organizations:

- PHAC established a funding agreement with the Canadian Red Cross to distribute and administer \$13 million to over 170 community-based organizations. It also conducted a targeted solicitation to organizations that had initially been unsuccessful in applying for MHBC (\$4.7 million) and MHP-IF (\$8.5 million) due to the high volume of applications. Several internal interviewees indicated that this was an efficient decision to leverage established programs and quickly administer funding in alignment with existing priorities in mental health promotion. A few internal interviewees noted that the use of the Canadian Red Cross to administer and further distribute funding under MH COVID allowed for faster allocation and reduced administrative burden.
- Remaining funding for the Supporting those Most Affected by COVID-19 program was administered through a general "Mobilizing Promotion, Prevention and Evaluation and Evaluation Across Multiple Delivery Points" stream, and targeted

solicitations in response to emerging mental health priorities, including targeted solicitation to First Nations, Inuit and Métis organizations, and organizations responding to the recommendations of the Mass Casualty Commission’s Final Report.

Internal interviewees reported that the MHBC program has also taken steps to improve its strategic funding allocation. To direct funding to areas of highest impact, the MHBC program convened a working group with a mandate to inform and direct the development and implementation of the funding program. For example, some internal interviewees reported that the working group identified the need for an 2SLGBTQI+ specific funding stream for Black Canadians, which was implemented in response to their recommendation.

Leveraging and partnership

Funded programs were encouraged to leverage partnerships, in-kind support and secure additional contributions. These partnerships and diverse funding streams were supportive of sustainability and future expansion of effective interventions.

For MHP-IF, partnerships were required to demonstrate the ability to scale their projects in order to receive funding. As shown in Table 2, in 2022-2023, over half of projects had funding from other sources totalling approximately \$11.6M. In many cases, the funding recipients were able to provide in-kind support, such as staff and volunteers. PTSD COVID projects also leveraged existing supports valued at an estimated \$7.8 million.

The 9-8-8 funding agreement uses a further distribution model, whereby CAMH acts as an intermediary to distribute funding to the distress centres that make up the 9-8-8 network. PHAC negotiated several memoranda of understanding with provinces and territories, except Quebec, outlining 9-8-8 roles and responsibilities. The Agency has had regular interaction with CAMH to address shared issues and exchange information.

Table 2. Partnerships and leveraged funding from recipients

Program	# of Funding Recipients	# of Partnerships	\$ Other Funding	\$ In-kind Support
MHP-IF (2022-2023)	20 in Phase 1 15 in Phase 2 1 Knowledge Hub	162	\$11,599,976	\$1,063,148

Program	# of Funding Recipients	# of Partnerships	\$ Other Funding	\$ In-kind Support
PTSD COVID (2023-2024)	12 Projects 1 Knowledge Hub	79	\$0	\$7,882,052
MHBC (2018-2024)	15 Projects	209	N/A	N/A

Spending on PHAC's mental health activities

Between 2019-2020 and 2024-2025, CMHW and CCDPHE spent approximately \$353.9 million dollars to support their activities related to mental health. This was approximately \$3 million over the planned budget, or 101% of planned spending. While overall spending closely approximates planned spending when examining the full evaluation period, there were some periods of overspending, most noticeably in 2023-2024 at 111% and underspending, most noticeably in 2024-2025 at 86% and 2020-2021 at 87%. These variances were largely due to over or under-spending in Grant and Contribution programs.

Overspending tended to be due to the need for extra funding to cover surge support during the COVID-19 pandemic, due to an internal reallocation of funds. Most notably, there was higher than planned spending for the Canada Suicide Prevention Service / Talk Suicide Canada in 2019-2020 and 2020-2021 related to increased demand due to COVID-19, and again in 2023-2024 to support the launch of 9-8-8 in Fall 2024.

Reasons for underspending across the G&Cs included the following:

- PHAC receiving the money later in the fiscal year;
- unanticipated delays in allocating funds to funding recipients;
- underspending by funding recipients; and
- delays in implementing planned projects during COVID as these projects were extended into the following year.

With the exception of 2023-2024 (133%), spending on salaries tended to be on par with planned spending while actual Operations and Maintenance (O&M) spending tended to fall short of planned spending levels. For example, O&M spending ranged from 51% - 59% of

planned amounts between 2019-2020 and 2021-2022. For more details on all spending please see Appendix D.

In addition to the HPCDPB funding noted above, CSAR reported on planned expenditures. CSAR had a total of \$18.1 million over six years in planned spending for mental health from multiple sources. Because CSAR's operates in an integrated manner on chronic disease and mental health surveillance, isolating actual expenditures for mental health activities specifically was not feasible for the evaluation.

Finally, CPAB conducts communications activities for a variety of themes supporting work from both Health Canada and PHAC, and did not maintain financial coding for their activities by subject matter, except where funding specifically came from another program, such as 9-8-8 funding. Therefore, financial data is limited to the years where CPAB received dedicated funding to provide communications support to a specific mental health program. CPAB spent approximately \$5 million per year in 2022-2023 and 2023-2024 providing communications support for 9-8-8. In 2023-2024, CPAB had significant overspending relative to initial planned budget for salary. The Branch had originally planned \$130,000 total salary dollars, and ended up spending 12.5 times more than originally planned (\$1.6 million) by the end of the year, due to a higher than anticipated level of effort needed to support promotion activities during the launch of 9-8-8.

Conclusions and Recommendations

Conclusions

PHAC's mental health activities are aligned with both the Agency's role within the health promotion sector and the legislative commitments of the federal government. PHAC's funding for 9-8-8 was considered appropriate since it fits its role as a convener, as service delivery occurs through a network of local, regional and national crisis and distress lines. By targeting programs and projects to specific populations disproportionately affected by mental health challenges, PHAC has successfully tailored its programming to respond to the needs of these groups. Through the strategic promotion of mental health resources, such as the 9-8-8 Suicide Crisis Helpline, the Agency has been able to cater to higher-risk populations, with activities informed by surveillance data on positive mental health, suicide and self-harm, and mental illness trends.

The impact of PHAC's initiatives is evident by the enhanced availability of mental health data, heightened awareness of what resources are accessible via Canada.ca, and expanded surveillance of positive mental health, suicide and self-harm, and mental illness.

Furthermore, investments in mental health promotion, facilitated through community organizations, have fostered the development of new mental health resources. While availability performance data was limited in some areas, evidence shows that participants in these programs have reported favorable outcomes from their participation, including improved health behaviors and protective factors.

Moreover, PHAC's collaboration with organizations like the Canadian Red Cross enabled more efficient funding distribution in response to the COVID-19 pandemic, showcasing the potential for this mechanism to be expanded in future crisis situations. Additionally, the need for a longer funding timeline was identified as crucial for supporting projects aimed at addressing social determinants of health and fostering localized relationship building.

Internal and external interviewees almost unanimously agreed that a clear expression of the Agency's priorities in the area of mental health would help direct future funding to established priorities. A coherent strategic plan would also help demonstrate PHAC's key activities to provinces, territories, and other actors in the mental health domain, potentially reducing an overlap in services and enhancing overall efficiency.

Recommendations

Recommendation 1: Consider developing a coherent strategic direction across all of PHAC activities supporting mental health.

While PHAC's activities for mental health are generally aligned with emerging issues, they are often driven by external demands, particularly as the agency addressed unprecedented challenges during the pandemic period, and there is a perceived lack of a coherent strategy tying together these activities. This can create challenges in terms of a siloed or fragmented approach to certain activities. Developing a coherent strategic direction or strategy could help clarify shared goals and priorities within the Agency and for external stakeholders.

Recommendation 2: Work to improve the consistent collection and reporting of performance data for funding recipients of PHAC's mental health programs.

In some program areas, particularly those with shorter-term funding and lower-value grant funding, there was a lack of performance information from funding recipients on key shared performance indicators. This presents challenges for management in understanding and communicating the shared impact of funded programs on overarching mental health priorities. Related to the first recommendation, it would be beneficial to

examine opportunities to improve the consistency of performance data collection across funding recipients, such as establishing shared performance indicators across PHAC-funded programs, where possible.

Appendix A: Methodology

Evaluation Questions

The evaluation seeks to answer three questions related to alignment, effectiveness, and efficiency of PHAC's mental health activities.

1. Is PHAC investing in areas that are consistent with a federal public health mandate?
 - a) Does the design and delivery of PHAC's mental health activities address differences in mental health needs across various population groups in Canada?
2. What impacts have PHAC's mental health activities had in the following areas:
 - a) Availability of mental health and mental illness data;
 - b) Canadians' access to mental health information and resources;
 - c) Use of evidence and knowledge products on mental health;
 - d) Improved protective factors and environments to support mental wellness;
 - e) Scaling of effective initiatives; and
 - f) Improved health behaviours related to mental wellness.
3. How efficient is PHAC's approach to its mental health activities?
 - a) What opportunities exist for further efficiencies?

Grants and contributions (G&Cs) programs included in review

The evaluation covers seven G&Cs programs administered by PHAC:

- Promoting Health Equity: Mental Health of Black Canadians Fund (MHBC)
- Mental Health Promotion Innovation Fund (MHP-IF)
- Kids Help Phone (KHP)
- Distress Line Investment (Supporting distress centres during the COVID-19 pandemic fund) (DLI)
- Canada Suicide Prevention Service and 9-8-8: Suicide Crisis Helpline (9-8-8)
- Supporting the Mental Health of those Most Affected by the COVID-19 Pandemic (MH COVID)
- Addressing PTSD and Trauma in Those Most Affected by COVID-19 (PTSD COVID)

Data Collection Sources and Methods

The evaluation draws on multiple lines of evidence to support assessment of the alignment, impacts, and efficiency of PHAC's mental health activities from April 2019 to December 2024.

Document and Performance Information Review

The evaluation reviewed internal documents from PHAC programs and G&Cs recipients, including the following:

- Program collected evaluation and performance reports;
- Solicitation documents, funding agreements, and annual reports from G&Cs funding recipients;
- Public opinion research commissioned on the topic of mental health;
- PHAC corporate reports, including CPHO annual reports and PHAC Departmental Results Reports;
- PHAC-published surveillance and research reports; and
- Web analytics data.

Case Studies

The evaluation included case studies on the Federal Framework on PTSD and the Knowledge Development and Mobilization Networks and Hubs to support evaluation findings. The case studies were conducted based on evidence from documents and key informant interviews.

Interviews

In total, 52 interviews were conducted with 81 individuals from the groups described in Table 3.

Table 3. Distribution of Interviewees

Category	Case study on Knowledge Hubs	Case study on Federal Framework on PTSD	Overall Evaluation Questions	Total
Federal Partners	0	5	0	5
Funding Recipient	3	6	22	31
PHAC and HC Staff	0	8	30	38
Subject Matter Experts	2	3	2	7
Total	5	22	54	81

Interviews were conducted individually or in groups of up to three participants working within the same team. Interviews were conducted over MS Teams and transcribed for accuracy. An interview summary was prepared using a standard template. Summaries were analyzed in NVIVO using a combination of inductive and deductive approaches, coding by both interview questions and themes. A summary was prepared describing the frequency and spread of themes across different interviewee groups, and is referred to in the text of this report.

Performance data review

An analysis of performance information profile data was conducted on the seven grant and contribution programs included in this evaluation. Furthermore, selected key performance indicators were included for surveillance and communications efforts. Data was collected by the program areas, and aggregated to demonstrate trends from 2019-2020 to 2023-2024.

Financial data review

To conduct the financial data review, the evaluation team collected planned and actual expenditure data from the centres responsible for administering mental health activities within the Health Promotion and Chronic Disease Prevention Branch, specifically the Centre for Mental Health and Wellness (CMHW), the Centre for Chronic Disease Prevention and Health Equity (CCCDPHE), and the Centre for Surveillance and Applied Research (CSAR), as well as data from the Communications and Public Affairs Branch (CPAB). Financial information from CSAR and CPAB was limited, as their work supports multiple areas of the Agency and their expenditures were not coded by specific activities or subject matter, such as 'mental health'.

Variance analysis was conducted to assess the difference between planned and actual expenditures, expressed in both total dollar amounts and as a percentage of planned spending. This process was also applied to G&Cs funding, with variance analysis conducted across the seven G&Cs programs.

Program representatives were given an opportunity to provide explanations for variances above or below 10% of planned expenditures.

Literature review

The evaluation included an assessment of recent peer-reviewed and grey literature on social determinants of mental health and mental health inequities in Canada. Articles that provided information relevant to the evaluation questions were summarized in a technical report.

Evidence Synthesis

The Office of Audit and Evaluation and the Office of the Chief Science Officer collaborated to commission an evidence synthesis through the McMaster Health Forum entitled “What is known about the design, governance, delivery and effects of national mental health and suicide prevention strategies?” The methodology for the evidence synthesis included the following elements.

- Structured and targeted searches: Academic literature was systematically searched using MedLine and Health Systems Evidence databases, with inclusion criteria applied. A recent systematic review and key informant suggestions were also reviewed for additional articles.

- Jurisdictional scan: Internet searches were used to identify national mental health and suicide prevention strategies launched in the past 10 years in OECD countries, followed by searches for evaluations or other grey or academic literature for each strategy. Examples with the richest evaluative findings were selected for inclusion in this report.
- Key informant interviews: Six international experts were identified in consultation with decision-maker partners, as well as through the literature review. Key informants were based in Europe, the United Kingdom, Australia, and Canada. Key informants were presented with a high-level summary of findings and followed a semi-structured interview guide to address gaps in the literature or elicit examples from practice.

Limitations

The evaluation team used triangulation to analyze data collected by various methods in order to increase the reliability and credibility of the evaluation findings and conclusions. Still, most evaluations face constraints that may affect the validity and reliability of findings. The table below outlines the limitations encountered during this evaluation and the mitigation strategies that were put in place.

Table 4. Limitations, impacts, and approach for addressing them

Limitation	Impact on the evaluation	Approach for addressing the limitation
PHAC's organizational structure for mental health activities does not include a mental health program.	PHAC does not have a mental health program. Therefore, evaluators examined the mental health activities across multiple centres and included multiple "programs" of different funding sizes, targeting different populations, and using differing program designs. At times it was difficult to determine the scope of which activities to include, leading to some lack of clarity around performance	The evaluation clearly defined the extent to which each G&Cs program affected overall results and, wherever appropriate, clarified which branches and centres were involved in determining findings and recommendations.

Limitation	Impact on the evaluation	Approach for addressing the limitation
	and financial data alignment.	
There was limited performance data for some G&Cs funded projects.	For some of the shorter-term contribution programs included in the review, performance data was requested but not required by funding recipients (e.g., MHBC – use of evidence and knowledge products, MH COVID and PTSD COVID – improved factors and environments to support positive mental health). For some grants, no performance data was provided. As such, for some indicators, a very small proportion of MHBC, MH-COVID, and PTSD COVID funding recipients actually provided data.	The evaluation refers to qualitative results reported in annual reports to supplement data gaps in quantitative indicators. The number of projects reporting on specific indicators is included in Appendix B. Therefore, these results can not be extrapolated to all projects, or all participants. The evaluation triangulates performance data findings with findings from other lines of evidence to ensure accuracy.

The evaluation applied an SGBA Plus lens to its assessment of the activities. An examination of the Sustainable Development Goals was not applicable for this evaluation.

The Office of Audit and Evaluation worked closely throughout the evaluation with program contacts in the Health Promotion and Chronic Diseases Prevention Branch (HPCDPB) and CPAB to access documents and performance data, and to identify individuals to participate in interviews. The scope of this evaluation was shared secretarially with the PHAC Performance Measurement and Evaluation Committee (PMEC) in October 2024 to receive input and guidance on the proposed questions. The preliminary findings were presented to PMEC in March 2025 and the final report and

Management Response and Action Plan (MRAP) developed by HPCDPB were also presented to this committee in June 2025.

Appendix B: Quantitative Results on Key Performance Indicators

Table 5. Access to Mental Health Information Generated by Funded Projects

Indicator	Program	2020-2021	2021-2022	2022-2023	2023-2024
# of Knowledge Products Developed	MHP-IF	96	270	133	159
	MH COVID	N/A	N/A	156	1,061
	MHBC	N/A	N/A	N/A	N/A
	PTSD COVID	N/A	N/A	349	476
# Knowledge Events Held	MH COVID	N/A	N/A	112	677
	MHBC	N/A	N/A	7	42
	PTSD COVID	N/A	N/A	274	339
# of Individuals Accessing Information from Funded Projects	MHP-IF	107,564	254,471	17,972	7,975
	MH COVID	N/A	N/A	222,925	3,091,972
	MHBC	4,332	7,743	19,250	18,737
	PTSD COVID	N/A	N/A	325,155	571,965

Indicator	Program	2020-2021	2021-2022	2022-2023	2023-2024
# of Professionals/ Service Providers Reached through funded projects	MHP-IF	1,408	1,683	6,462	1,555
	MH COVID	N/A	N/A	7,021	54,084
	MHBC	5,080	1,870	2,433	6,158
	PTSD COVID	N/A	N/A	63,885	51,518
# of Project Delivery Sites through funded projects	MHP-IF*	71	95	209	800
	MH COVID	N/A	N/A	464	1,206
	MHBC	N/A	Not Available	9	54
	PTSD COVID	N/A	N/A	150	168

* Does not include virtual sites

Table 6. Access to Suicide Crisis Services

Indicator	2020-2021	2021-2022	2022-2023	2023-2024
# of Talk Suicide/ 9-8-8 serviceable calls answered	Calls/Voice: 57,521 Texts: 14,339 Total: 71,860	Calls/Voice: 74,663 Text: 14,225 Total: 88,888	Calls/Voice: 63,970 Text: 24,298 Total: 88,268	Calls/Voice: 84,751 Text: 50,712 Total: 135,463*
# distress centres funded during the COVID pandemic	42 Centres	28 Centres	1 Centre	N/A
# of interactions on KHP	Total Interactions: 365,606 Voice: 147,462 Text: 218,114 Chat: 0	Total Interactions: 384,651 Voice: 169,448 Text: 200,567 Chat: 14,636	Total Interactions: 384,651 Voice: 169,448 Text: 200,567 Chat: 14,636	Not Yet Reported
# KHP “Live Rescues” / Emergency Service Deployed	4,674	4,389	3,167**	Not Yet Reported
# New professionals hired for KHP	80	155	125	Not Yet Reported

Wait Time for KHP Calls	Phone: 4:30 Text: 0:46	Phone: 5:59 Text: 3:38	Phone: 5:12 Text: 5:26**	Not Yet Reported
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* Data is from Launch of 9-8-8 on November 30, 2023 to March 31, 2024.

**Data is from Q1-Q3, as program suggested KHP focus on the development of the final report, which included accumulative project totals

Table 7. Percentage of Participants Using Health Promotion Evidence

Program	2020-2021	2021-2022	2022-2023	2023-2024
MH COVID	Not Applicable	Not Available	4/26 projects reported 79% of participants surveyed	8/32 projects reported 81% of participants surveyed
PTSD COVID	Not Applicable	Not Available	5/14 projects reported 88% of participants surveyed	7/14 projects reported 52% of participants surveyed
MHP-IF*	3/20 reported on use quantitatively 100% of projects reported some use.	5/20 reported on use quantitatively 97% of participants surveyed reported using products.	4/15 reported on use quantitatively 98% of participants surveyed reporting using products.	4/15 reported on use quantitatively 86% of participants surveyed report using products.

* MHP-IF collects qualitative and quantitative data to monitor project implementation and report on progress against the MHP-IF program outputs and outcomes identified in the logic model for Health Promotion and for Building Evidence (Agency level logic models) including the use of MHP-IF evidence, improved protective factors, and improved health behaviours.

The MHPIF program encourages projects to use research and evaluation methods which are culturally appropriate and best able to capture the impact of their intervention, this includes qualitative methods. In Phase 2, Year 2 (2023-2024), 13/16 projects were using a mix of quantitative and qualitative methods to report their outcomes. One project only used qualitative results, and two projects used only quantitative results. The results presented in this table and those that follow do not capture qualitative results.

Table 8. Improved Protective Factors and Social Environments

Indicator	Program	2020-2021	2021-2022	2022-2023	2023-2024
% of participants who experienced improved protective factors as a result of programming	MHP-IF	6/20 projects reported 55% of participants surveyed	15/20 projects reported 56% of participants surveyed	10/15 of projects reported 43% of participants surveyed	13/15 of projects reported 59% of participants surveyed
% of participants who reported social environments are improved to support ongoing healthy behaviour	MHBC	2/9 projects reported 66% of participants surveyed	3/12 projects reported 70% of participants surveyed	4/12 projects reported 56% of participants surveyed	3/10 projects reported 64% of participants surveyed

Table 9. Improved Health Behaviours

Indicator	Program	2020-2021	2021-2022	2022-2023	2023-2024
Number of projects Reporting Increased Knowledge or Skills as a Result of Intervention	MHP-IF	20/20 projects reported Percentage of participants reporting change not available	10/20 projects reported 86% of participants surveyed	13/15 projects reported 77% of participants surveyed	14/15 projects reported 70% of participants surveyed
	MH COVID	N/A	N/A	7/26 projects reported 76% of participants surveyed	12/32 projects reported 88% of participants surveyed
	MHBC	5/9 projects reported 73% of participants surveyed	4/9 projects reported 77% of participants surveyed	5/12 projects reported 85% of participants surveyed	6/10 projects reported 84% of participants surveyed
	PTSD COVID	N/A	N/A	6/14 projects reported 88% of participants surveyed	8/14 projects reported 82% of participants surveyed

Indicator	Program	2020-2021	2021-2022	2022-2023	2023-2024
% of participants who stated their mental health and wellbeing is better as a result of programming	MHP-IF	6/20 projects reported 59% of participants surveyed.	15/20 projects reported 56% of participants surveyed.	8/15 projects reported 52% of participants surveyed.	10/15 projects reported 52% of participants surveyed.
	MH COVID	N/A	N/A	2/26 of projects 90% of participants surveyed	10/32 of projects 80% of participants surveyed
	PTSD COVID	N/A	N/A	1/14 Projects 90% of participants surveyed	0/14 projects
% of projects reporting positive change in behaviour among participants	MHP-IF	10/20 reported 100% of these showed improved results	16/20 reported 100% of these showed improved results	8/15 reported 100% of these showed improved results	13/15 reported 100% of these showed improved results
	PTSD COVID	N/A	N/A	5/14 reported 100% of these showed improved results	8/14 reported 100% of these showed improved results

Indicator	Program	2020-2021	2021-2022	2022-2023	2023-2024
	MH-COVID	N/A	N/A	7/26 reported 100% of these showed improved results	12/32 reported 100% of these showed improved results
% of participants reporting positive change in behaviour	MHP-IF	64% of participants surveyed	65% of participants surveyed	72% of participants surveyed	79% of participants surveyed
	PTSD COVID	N/A	N/A	77% of participants surveyed	62% of participants surveyed
	MH-COVID	N/A	N/A	83% of participants surveyed	80% of participants surveyed
% of project participants demonstrating skills/ability to support healthy behaviour	MHBC	3/9 projects reported	5/12 projects reported	5/12 projects reported	4/10 projects reported
		64% of participants surveyed	67% of participants surveyed	77% of participants surveyed	83% of participants surveyed
% of project participants who improved health status	MHBC	1/9 projects reported	3/12 projects reported	4/12 projects reported	2/10 projects reported
		63% of participants surveyed	63% of participants surveyed	65% of participants surveyed	86% of participants surveyed

Appendix C: Case Study on Knowledge Hubs

MHP-IF and MH COVID Knowledge Hub: KDE Hub



- The MHP-IF and MH COVID programs have funded the Knowledge Development and Exchange Hub for Mental Health Promotion (KDE Hub) to provide support to funded projects and promote the knowledge produced by their activities.

- The KDE Hub supports funded projects through webinars, an annual symposium, and sharing lessons learned across projects. The Hub supported knowledge promotion related to MHP-IF and MH COVID projects by creating infographics on projects, and distributing the “Hub Updates” Newsletter, which had approximately 460 subscribers in 2022-2023.
- In 2022-2023, the KDE Hub website was viewed 34,711 times. The number of unique views more than doubled since the website launched in 2020-2021, with 13,085 views that year.
- Some interviewees reported that the KDE Hub activities were predominantly focused on supporting knowledge development and exchange among funding recipients, who were also the primary audience for most of their knowledge promotion activities. A few felt there was an opportunity for expanded activities to promote work to a general audience interested in mental health promotion.

MHBC Knowledge Mobilization Network: Amandla Olwazi



- The MHBC Knowledge Mobilization Network shares information like project summaries and infographics, and resources like final products developed by MHBC-funded projects,

through their website.

- The role of the MHBC Knowledge Mobilization Network is to facilitate connections and knowledge exchange between researchers, professionals, community based organizations and the public regarding mental health of Black people in Canada and its determinants, with a primary focus on mobilizing the findings from projects

supported by the MHBC Fund. This includes activities such as the Black Wellness Network website and the Act Now! Conferences in March in 2023, and 2024.

- The project holds monthly meetings with project authorities, partners and advisory members, but does not track participation.
- A key deliverable has been the Act Now Conference. The goal of the conference is to “generate opportunities for Afrocentric knowledge sharing and gathering, knowledge mobilization, and networking while centering on Black mental health in Canada.”³⁶
- The Act Now Conference was attended by 213 individuals (121 in-person and 92 virtually) in 2023 and over 360 individuals (260 in-person and 100+ virtually) in 2024. In 2024, the most represented sectors were mental health services (33%), community health (18%), social services (15%) and primary care (7%)”. Feedback collected by Taibu indicated that following the 2024 conference:
 - 95% of conference attendees reported applying or using acquired knowledge in their daily life.
 - 89% of conference attendees demonstrated using or having the intention to use acquired knowledge in their professional activities regarding mental health and its determinants affecting Black people in Canada.³⁷
- One of the Calls emerging from the 2023 Act Now Conference was the need for a National Black Mental Health Strategy to address the patchwork of short-term funding available for Black mental health initiatives. The main themes were Knowledge and Awareness, Stigma, and Healing and Wellness.
- The MHBC program was renewed in 2024 for an additional two years, until March 2026. The TAIBU Community Health Centre was approved by the MHBC Fund to maintain the national knowledge mobilization network and facilitate knowledge and capacity building of MHBC funded projects.

Appendix D: Financial Analysis

Financial Information – HPCDP (Excludes CSAR)

	Planned	Actual	Variance	% of Planned
2019-2020				
FTE	26	26	0	
Total Salary	\$2,990,180.32	\$3,181,005.55	-\$190,825.24	106%
G&Cs	\$4,304,792.00	\$4,601,141.00	-\$296,349.00	107%
O&M	\$726,912.00	\$410,415.65	\$316,496.35	56%
Total:	\$8,021,884.32	\$8,192,562.20	-\$170,677.89	102%
2020-2021				
FTE	27.5	28.5	-1	
Total Salary	\$3,237,633.07	\$3,425,713.60	-\$188,080.53	106%
G&Cs	\$26,579,000.00	\$22,732,738.00	\$3,846,262.00	86%
O&M	\$755,912.00	\$446,217.56	\$309,694.44	59%
Total	\$30,572,545.07	\$26,604,669.16	\$3,967,875.91	87%
2021-22				
FTE	35.5	35.56	-0.06	
Total Salary	\$4,152,067.56	\$4,073,221.76	\$78,845.80	98%
G&Cs	\$25,809,357.00	\$23,600,075.00	\$2,209,282.00	91%

	Planned	Actual	Variance	% of Planned
O&M	\$562,431.00	\$289,200.80	\$273,230.20	51%
Total	\$30,523,855.56	\$27,962,497.56	\$2,561,358.00	92%
2022-23				
FTE	44.25	44.75	-0.5	
Total Salary	\$5,725,574.22	\$5,786,928.04	-\$61,353.81	101%
G&Cs	\$102,761,309.00	\$92,438,884.00	\$10,322,425.00	90%
O&M	\$4,470,711.15	\$4,416,587.81	\$54,123.34	99%
Total	\$112,957,594.37	\$102,642,399.85	\$10,315,194.53	91%
2023-24				
FTE	54.5	57.5	-3	
Total Salary	\$6,452,114.13	\$8,603,748.33	-\$2,151,634.20	133%
G&Cs	\$91,207,043.00	\$101,406,875.00	-\$10,199,832.00	111%
O&M	\$6,922,784.61	\$6,099,395.28	\$823,389.33	88%
Total:	\$104,581,941.74	\$116,110,018.61	-\$11,528,076.87	111%
2024-25				
FTE	52	49	3	
Total Salary	\$6,424,877.98	\$6,111,794.27	\$313,083.71	95%
G&Cs	\$75,564,523.00	\$63,883,367.00	\$11,681,156.00	85%

	Planned	Actual	Variance	% of Planned
O&M	\$2,665,863.00	\$2,470,844.69	\$195,018.31	93%
Total	\$84,655,263.98	\$72,466,005.96	\$12,189,258.02	86%
Grand Total	\$371,313,085.03	\$353,978,153.33	\$17,334,931.70	95%

Financial Information - Mental Health Activities, HPCDPB – CSAR

CSAR reported on planned expenditures. CSAR had a total of \$18.1 million over six years in planned spending for mental health from multiple sources. Because CSAR's operates in an integrated manner on chronic disease and mental health surveillance, actual expenditures for mental health activities could not be isolated for this evaluation.

Financial Information – Mental Health Activities, CPAB

	Planned	Actual	Variance	% of Planned
2019-20				
FTE	0	0	0	N/A
Total Salary	\$0	\$0	\$0	N/A
O&M	\$0	\$0	\$0	N/A
Total	\$0	\$0	\$0	N/A
2020-21				
FTE	0	0	0	N/A
Total Salary	\$0	\$0	\$0	N/A
O&M	\$0	\$0	\$0	N/A

	Planned	Actual	Variance	% of Planned
Total	\$0	\$0	\$0	N/A
2021-22				
FTE	0	0	0	N/A
Total Salary		7,279	7,279	N/A
O&M	\$0	\$0	\$0	N/A
Total	\$0	\$7,279	\$7,279	N/A
2022-23				
FTE	0	5	0	N/A
Total Salary	\$661,430	\$568,050	\$93,380	86%
O&M	\$3,786,808	\$3,813,165	-\$26,357	101%
Total	\$4,448,238	\$4,381,215	\$67,023	98%
2023-24				
FTE	0	12	0	N/A
Total Salary	\$130,005	\$1,643,661	-\$1,513,656	1,264%
O&M	\$5,091,007	\$4,426,621	\$664,386	87%
Total	\$5,221,012	\$6,070,282	-\$849,270	116%
2024-25				
FTE	0	6		

	Planned	Actual	Variance	% of Planned
Total Salary	\$0	\$759,986	-\$759,986	
O&M	\$2,000,000	\$1,985,159	\$14,841	99%
Total	\$2,000,000	\$2,745,145	-\$745,145	137%
Grand Total	\$11,669,250	\$13,203,921	-\$1,601,694	113%

Financial Information – Grant and Contribution Programs for Mental Health

Program/Year	Planned	Actual	Variance	% of Planned
2019-20				
MHP-IF	\$1,536,792	\$1,536,792	\$0	100%
MHBC	\$1,765,000	\$1,607,155	\$157,845	91%
MH COVID	\$0	\$0	\$0	N/A
PTSD	\$0	\$0	\$0	N/A
Talk Suicide/988	\$1,003,000	\$1,457,194	-\$454,194	145%
Distress Line Fund	\$0	\$0	\$0	N/A
Kids Help Phone	\$0	\$0	\$0	N/A
Total	\$4,304,792	\$4,601,141	-\$296,349	107%
2020-21				

Program/Year	Planned	Actual	Variance	% of Planned
MHP-IF	\$4,947,000	\$5,359,087	-\$412,087	108%
MHBC	\$1,865,000	\$1,458,618	\$406,382	78%
MH COVID	\$0	\$0	\$0	N/A
PTSD	\$0	\$0	\$0	N/A
Talk Suicide/988	\$4,267,000	\$4,814,268	-\$547,268	113%
Distress Line Fund	\$8,000,000	\$6,900,000	\$1,100,000	86%
Kids Help Phone	\$7,500,000	\$4,200,765	\$3,299,235	56%
Total	\$26,579,000	\$22,732,738	\$3,846,262	86%
2021-22				
MHP-IF	\$4,947,000	\$4,807,212	\$139,788	97%
MHBC	\$1,675,000	\$1,574,692	\$100,308	94%
MH COVID	\$2,621,128	\$390,054	\$0	100%
PTSD		\$2,231,074		
Talk Suicide/988	\$6,267,000	\$4,342,584	\$1,924,416	69%
Distress Line Fund	\$5,545,382	\$5,500,612	\$44,770	99%

Program/Year	Planned	Actual	Variance	% of Planned
Kids Help Phone	\$4,753,847	\$4,753,847	\$0	100%
Total	\$25,809,357	\$23,600,075	\$2,209,282	91%
2022-23				
MHP-IF	\$4,947,000	\$4,939,129	\$7,871	100%
MHBC	\$2,160,000	\$1,955,165	\$204,835	91%
MH COVID	\$45,987,309	\$46,893,278	-\$905,969	102%
PTSD	\$32,400,000	\$22,702,946	\$9,697,054	70%
Talk Suicide/988	\$4,267,000	\$4,700,000	-\$433,000	110%
Distress Line Fund	\$7,400,000	\$5,951,117	\$1,448,883	80%
Kids Help Phone	\$5,600,000	\$5,297,249	\$302,751	95%
Total	\$102,761,309	\$92,438,884	\$10,322,425	90%
2023-24				
MHP-IF	\$4,947,000	\$4,956,756	-\$9,756	100%
MHBC	\$1,640,000	\$1,508,375	\$131,625	92%
MH COVID	\$47,301,503	\$44,978,991	\$2,322,512	95%
PTSD	\$11,051,540	\$10,695,753	\$355,787	97%

Program/Year	Planned	Actual	Variance	% of Planned
Talk Suicide/988	\$4,267,000	\$17,267,000	-\$13,000,000	405%
Distress Line Fund	\$22,000,000	\$22,000,000	\$0	100%
Kids Help Phone	\$0	\$0	\$0	N/A
Total	\$91,207,043	\$101,406,875	-\$10,199,832	111%
2024-25				
MHP-IF	\$5,181,941	\$5,107,341	\$74,600	99%
MHBC	\$1,500,000	\$1,103,216	\$396,784	74%
MH COVID	\$10,315,582	\$10,299,440	\$16,142	100%
PTSD	\$0	\$0	\$0	N/A
Talk Suicide/988	\$58,567,000	\$47,373,370	\$11,193,630	81%
Distress Line Fund	\$0	\$0	\$0	N/A
Kids Help Phone	\$0	\$0	\$0	N/A
Total	\$75,564,523	\$63,883,367	\$11,681,156	85%
Grand Total	\$326,226,024	\$308,663,080	\$17,562,944	95%

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