Every Door is the Right Door

Towards a 10-Year Mental Health and Addictions Strategy
A discussion paper

July 2009

Ontario

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An Invitation: We Need Your Help to Improve Mental Health and Addictions Services in Ontario

In 2008, our Government made a commitment to strengthen mental health and addiction services in the province, including cutting wait times in emergency departments for people with mental illnesses and addictions and providing better care for people with eating disorders or early psychosis. We also promised to develop a comprehensive mental health and addiction strategy that would lead to better services for Ontarians.

In October 2008, I established an Advisory Group made up of people with lived experience with mental illnesses and addictions, family members, service providers and researchers. They are helping to develop a new 10-year strategy that can transform mental health and addiction services in Ontario.

- For the first time, mental health, problematic substance use and problem gambling services will be integrated into the same strategy – instead of in separate silos.
- For the first time, we will develop a strategy that continues to focus on people with serious mental illnesses but also includes services for people with mild to moderate symptoms of moderate mental illness.
- For the first time, the strategy will include promoting health and preventing mental illnesses and addictions, as well as providing high quality treatment.
- For the first time, the province's strategy will look beyond the specialized mental health and addiction services funded by the Ministry of Health and Long-Term Care and the Ministry of Children and Youth Services, to the other *health* services that people with mental illnesses and addiction use, such as family health care services, home care and long-term care.
- For the first time, the province's strategy will also look beyond health to include all the other services used by people with mental illnesses and addictions, which are funded by other ministries, including Health Promotion, Education, Community and Social Services, Citizenship and Immigration, Community Safety and Correctional Services, and the Attorney General.

We Want Your Views – We Need to Get the Plan Right

Every Door is the Right Door is a consultation paper developed by the Minister's Advisory Group. It sets out a framework for the proposed strategy, which I introduced at a Summit on Mental Health and Addictions (July 13 and 14, 2009). Now I need your help and advice. Through a series of roundtables and other public forums, we are seeking the views of Ontarians who are familiar with mental health and addiction services as well as those who are not.

Do you share our vision? Are these the right goals and strategic directions? What specific actions should Ontario take to achieve our goals? Who should be involved? How can we work together to make a difference in the lives of people with mental illnesses and addictions?

As we move forward with this strategy, we must also be mindful that the world economy is facing challenges not seen since World War II. Health care already accounts for almost 40% of the provincial budget and I believe that we can work with our existing resources to make positive change for Ontarians with mental illnesses and addictions.

Your perspectives will be used to develop a 10-year plan that will help us map out where we want to go and the levers we can use over time to change the system. Through this strategy, we can bring together the strengths, energy and resources of all stakeholders to dramatically improve people's lives.

Please help us improve the health and well-being of all Ontarians. Help us support the passionate and dedicated people who use and provide services, and create supportive communities for people with mental illnesses and/or addictions.

The Honourable David Caplan
Minister of Health and Long-Term Care

Message from the Minister's Advisory Group

Hundreds of thousands of Ontarians struggle with mental illnesses and addictions. The Government has tried before to develop both mental health and addiction strategies, but many of the long-standing problems remain. Why will this strategy be different?

- Because we are proposing a different way of thinking about people with mental illnesses and addictions and involving them in their health – and structural change – a different way of organizing and providing services that can lead to better care.
- Because the process to develop the strategy is highly inclusive and participatory. The establishment of the Advisory Group is a testament to the Government's willingness to listen to and hear from highly skilled, committed people in the field – providers, people with lived experience, families, researchers and other ministries and sectors.
- Because there is a growing body of knowledge about mental illnesses and addictions, and how best to prevent, treat and manage them, as well as evidence about how to provide efficient services and make the best use of resources.
- Because there is a growing awareness of the need for action and opportunities for collaboration with the Mental Health Commission of Canada, the Canadian Centre on Substance Abuse, other ministries, and the business community, among others.

We believe the proposed approach has the potential to transform lives and the health system. It can help providers and people with lived experience work together in effective partnerships, and improve health outcomes.

The Process

The process used to develop this consultation paper has been inclusive. The Minister's Advisory Group is made up of people with lived experience of mental illness and addiction, family members, health care providers and researchers. It reflects a range of perspectives, such as children and youth, aboriginal peoples, seniors, women and adults, and in the workplace.

The members of the Minister's Advisory Group have met over the past eight months, discussed the issues and developed strategic themes. As part of our work, we formed five theme groups with a variety of leaders on the following topics: system design, healthy communities, consumer partnerships, early identification and early intervention, and supporting the mental health and addictions workforce. We held two intensive two-day workshops, that involved people from across the province, to identify strategic directions and priorities. A series of background papers to gather evidence was commissioned to inform our work. We consulted with provincial organizations, as well as people with lived experience and their families. The Local Health Integration Networks (LHINs) are holding similar consultations at the local level.

In addition, we are pleased that the Minister of Health and Long-term Care has established an interministerial group of his colleagues to contribute to the development of the 10-year strategy on mental health and addictions. An Assistant Deputy Ministers group has been formed to conduct a government-wide environmental scan of services, policies and initiatives that affect people with

mental illnesses and addictions. We look forward to seeing this environmental scan and hearing their advice on priorities and opportunities for collaboration that can improve services and supports for Ontarians.

We invite you to provide feedback on the proposed strategic directions and priorities in this paper. We also want to hear from you about what initiatives can help transform the system, and how you can contribute.

We plan to gather input in a number of ways:

- a broad public consultation through web comments
- roundtables to discuss issues and opportunities for children and youth, aboriginals, seniors, business, and justice
- liaison with the interministerial ADM committee on opportunities for improvements and ways to lever change
- more consultation with consumers, front line providers and provincial organizations.

We will use this input to provide advice to the Minister of Health and Long-Term Care on a 10-year strategic plan for mental health and addictions, including sequencing priorities, identifying where to start and who to involve, and establishing performance targets to measure progress.

Ministries Involved in the Mental Health and Addictions Strategy

- Aboriginal Affairs
- Attorney General
- Children and Youth Services
- Citizenship and Immigration
- Community and Social Services
- Community Safety and Correctional Services
- Culture
- Education
- Finance
- Health and Long-Term Care
- Health Promotion
- Labour
- Municipal Affairs
- Training, Colleges and Universities

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Executive Summary

Opening Doors for People with Mental Illnesses and Addictions

For too many years, people with mental illnesses and/or addictions have been marginalized and stigmatized. Mental health and addiction services have been the distant cousins of the health care system: planned and managed separately from other health services.

But there is no health without mental health. This proposed approach aims to integrate people with mental illnesses and/or addictions into their communities and to integrate mental health and addiction services with the rest of the health system – to make every door the right door for people with mental illnesses and/or addictions.

Our vision is that every Ontarian enjoys good health and well-being, and Ontarians with mild to complex mental illness and/or addiction live and participate in welcoming, supportive communities.

Our goals are clear:
- Improve health and well-being for all Ontarians
- Reduce incidence of mental illness and addiction
- Identify mental illnesses and addictions early and intervene appropriately
- Provide high quality, effective, integrated, culturally competent, person-directed services and supports for Ontarians with mild to complex mental illnesses and/or addictions.

Our proposed approach is guided by principles of respect for people with mental illnesses and/or addictions and their diverse strengths and needs. It is also based on the strong belief that people with lived experience must be active partners in their own recovery, and that all service providers have a responsibility to collaborate to provide seamless care. We believe that everyone in Ontario with mental illness or an addiction should be hopeful about their future because services can be evidence-based, strengths-based and provide opportunities for healthy development and recovery.

The system should make every effort to reduce the health, economic and social harms associated with mental illnesses, problematic substance use and harmful gambling. It can be innovative, and work to reduce or eliminate the underlying social factors that contribute to mental illness and addiction.

Transforming the System, Transforming Lives	
Where We Are Now	**Where We Want to Be**
Prevention is overlooked	Prevention and early identification are priorities
The system helps only people who reach services	The system reaches out to the whole population and all who need help
Services focus on treatment	Services focus on healthy development, recovery and harm reduction
Care is disease or provider-centred	Care is person-driven and family-centred
People with mental illnesses and/or addictions have limited support to manage their own care	People with mental illnesses and/or addictions are empowered and supported to manage their own care
Care is reactive and episodic	Care is proactive and ongoing
Providers and programs work in isolation	Providers and programs work collaboratively
Services plan and operate in separate silos	Services are integrated and coordinated
There is a sense of isolation and frustration	There is a culture of improvement and innovation
The system uses data and measurement for reporting	The system uses data and measurement to improve services

Making Every Door the Right Door

Right now, Ontario has a fragmented system of services. People go through too many doors and struggle finding the services they need. In most cases, services are not integrated. They do not work together to meet people's needs.

To make every door the right door for people with mental illnesses and/or addictions, we are proposing seven directions:

1. **Act Early:** Identify mental health and addiction problems early and intervene appropriately.

   We see an Ontario where a wide range of people and places – individuals, family members, peers, family health providers, schools, workplaces and communities – are able to identify the signs of mental illness and addiction and take action, helping people find the best door for help and care.

2. **Meet People on their Terms:** Develop a range of evidence-based, person-directed services.

   People with mental illnesses and/or addictions are empowered to be active partners in their own recovery, making informed decisions about their care, and the system offers a broad range of approaches to care, including healthy development, psychosocial rehabilitation, recovery, harm reduction and trauma-informed services.

3. **Transform the System:** Provide access to a seamless system of comprehensive, effective, efficient, proactive and population-based services and supports by revaluating current resources.

   The system provides a range of evidence-based services that are coordinated with other health services, and with other services that people with lived experience use, such as education, social services, housing and employment programs.

4. **Strengthen the Mental Health and Addictions Workforce:** Ensure we have the right people with the right skills in the right places.

   Sharing knowledge and promoting respectful, evidence-based services for people with mental illnesses and addictions is about taking a competency approach to care. Recognizing the value of life experience as well as academic training can help build a stronger and more efficient workforce.

5. **Stop Stigma:** Bring mental illness and addiction out from behind closed doors.

   Ontario eradicates stigma in the health system, in public services, and in society. We create healthy, supportive communities.

6. **Create Healthy Communities:** Fostering supportive communities is a shared responsibility that requires the commitment of all segments of society and cooperation of all government ministries.

7. **Build Community Resilience:** Take a strengths-based approach to protect people from mental illness and addictions.

   Strengths such as family and friends, problem-solving skills, coping style, social skills and being connected to the community can help build resilience and protect people from mental illnesses and addictions. Communities are active partners in promoting health and wellness, and social inclusion.

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I. Mental Illnesses and Addictions Touch Many Lives

Mental illnesses and addictions are serious health problems that cause great hardship for too many Ontarians and their families and friends.

1 in 5 Ontarians will have a mental illness or addiction

At some time in their lives, about 20% of Ontarians – one in every five people – will experience a serious mental illness or harmful substance use,[1] and 5% will have a serious problem with gambling.[2] Between 15% and 21% of children and youth in Ontario have at least one mental health issue.[3]

The most common mental illnesses and addictions in Ontario are anxiety, depression and alcohol dependence. Women are more likely to suffer from depression and anxiety, while men are more likely to struggle with addictions. Men are more likely than women to drink harmfully, to drink and drive, and to report having alcohol problems.[4] The most common mental illnesses for children and youth (ages 15 to 17) are anxiety disorder, attention deficit/hyperactivity, conduct disorder, depression and substance abuse.[5]

Mental illnesses and addictions include but are not limited to:

- psychotic disorders
- substance abuse and addictions, including problem gambling
- mood and anxiety disorders
- personality disorders
- eating disorders
- attention deficit hyperactivity disorder
- conduct disorder
- dementias

Most Ontarians who experience a mental illness will have relatively mild symptoms that will pass with time, a change in their situation or treatment. However, between two and three of every 100 Ontarians will have a serious or complex mental illness or addiction that they will have to cope with throughout their lives.[6] [7] A very small number may come into contact with the criminal justice system and require specialized forensic interventions (i.e., secure detention and/or continuing contact with the legal and judicial system).[8]

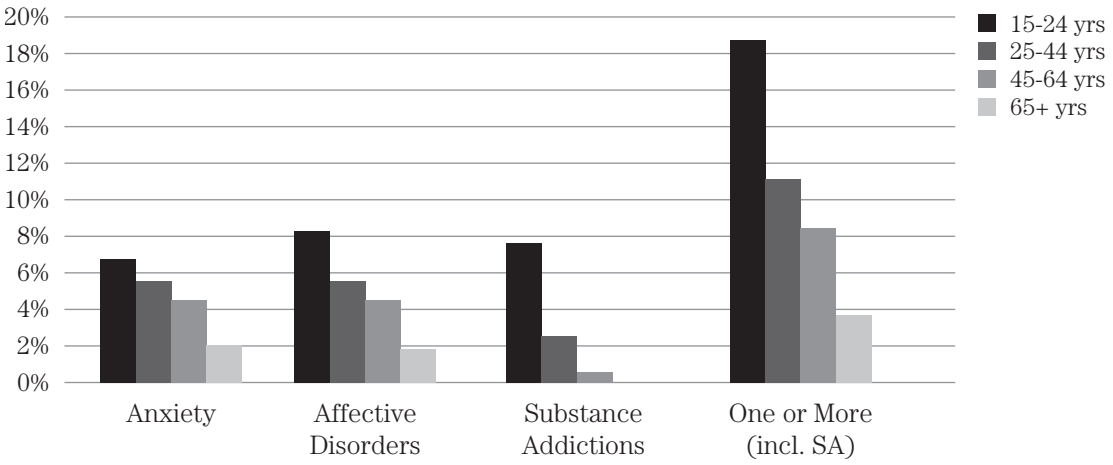
Mental illnesses and addictions affect Ontarians at all ages and stages of life

Mental health and addictions affect children, youth, young adults, people in mid-life and seniors. They affect people of all cultures and backgrounds. Some Ontarians are particularly vulnerable to mental health and addiction problems, including people who struggle with poverty and homelessness, and people who have experienced trauma, violence or abuse.

Mental health and substance use problems often start young

Ontarians between the ages of 15 and 24 are three times more likely to have a substance use problem than people over age 24. They are also more likely to experience mood disorders, such as depression, and anxiety:[9] 5% of children and youth experience depression before age 19.[10] Young people are more likely than adults to use stimulant drugs such as ecstasy and cocaine. They are more likely to use prescription drugs for non-medical reasons and to binge drink. They are also more likely to gamble.[11] [12] Most first episodes of psychosis occur in people between the ages of 15 and 34.

Figure 1: One-Year Prevalence of Certain Mental Illnesses by Age in Ontario



Source: Canadian Community Health Survey 1.2, Statistics Canada – Catalogue #82-617-XIE.

Some problems develop with age and are unique to seniors

Ten to 25% of seniors experience mental health disorders,[13] such as depression, usually related to medical illness, disability and social or emotional isolation. With age, many people experience cognitive changes and neurological disorders that affect their well-being. By age 80, dementia affects one in three people. Seniors are at high risk of both mental illness and problematic substance use during critical transitions in their lives, such as the loss of a spouse, caring for a spouse with dementia or moving to a long-term care home.

There is a close link between mental illnesses and addictions

Many people who have a mental illness, such as depression, bipolar disorder or schizophrenia, will also use substances or gamble in a harmful way – and vice versa.

About three of every 10 people with a mental illness will be dependent on alcohol or drugs. About four of every 10 people who use alcohol in a harmful way and over half of people who use other substances in a harmful way will have a mental illness at some time in their lives.[14] About three in 10 people who entered problem gambling programs in Ontario in 2004/05 also reported problems with substance use.[15]

Because mental illnesses and addictions are so closely linked, mental health and addictions services must be integrated.

Mental illnesses and addictions cost us all

Individuals and families suffer

Mental illnesses and addictions are devastating for the people who experience them, and heart-breaking for their loved ones. They cause great pain, sorrow, anger and fear. They can destroy families and relationships. They can lead people to lose their jobs, their homes, their friends – even their lives. For every 100,000 people in Ontario, we lose about 255 years of life to suicide. In fact, suicide[16] is the second

leading cause of death (after accidents) among 15 to 19 year olds.[17] According to a recent study by Canadian researchers, one of every 25 deaths worldwide is linked to alcohol consumption.[18] Because mental illnesses and addictions are not well understood, they can also affect communities, creating stigma and fear, and tearing at the fabric of our society.

Economic costs are high

Mental illnesses and addictions cost Ontario in health and well-being. They also cost the province and its people economically. In 2007-08, Ontario's health care system spent more than $2.5 billion on mental health and addiction services, including hospital care, community-based programs, medications and physician services.

The Ministry of Children and Youth Services' planned expenditures of $452 million in 2008/09 included: $384 million to support mental health services for children and youth, and $68 million to serve children with complex special needs. The funding is used for assessment and treatment services, social supports, prevention services and parent/caregiver education, training and other supports.

Other ministries, such as Education, Community and Social Services, and Community Safety and Correctional Services, also fund services for people with mental illnesses and addictions, but the amount of their spending is not captured in these figures.

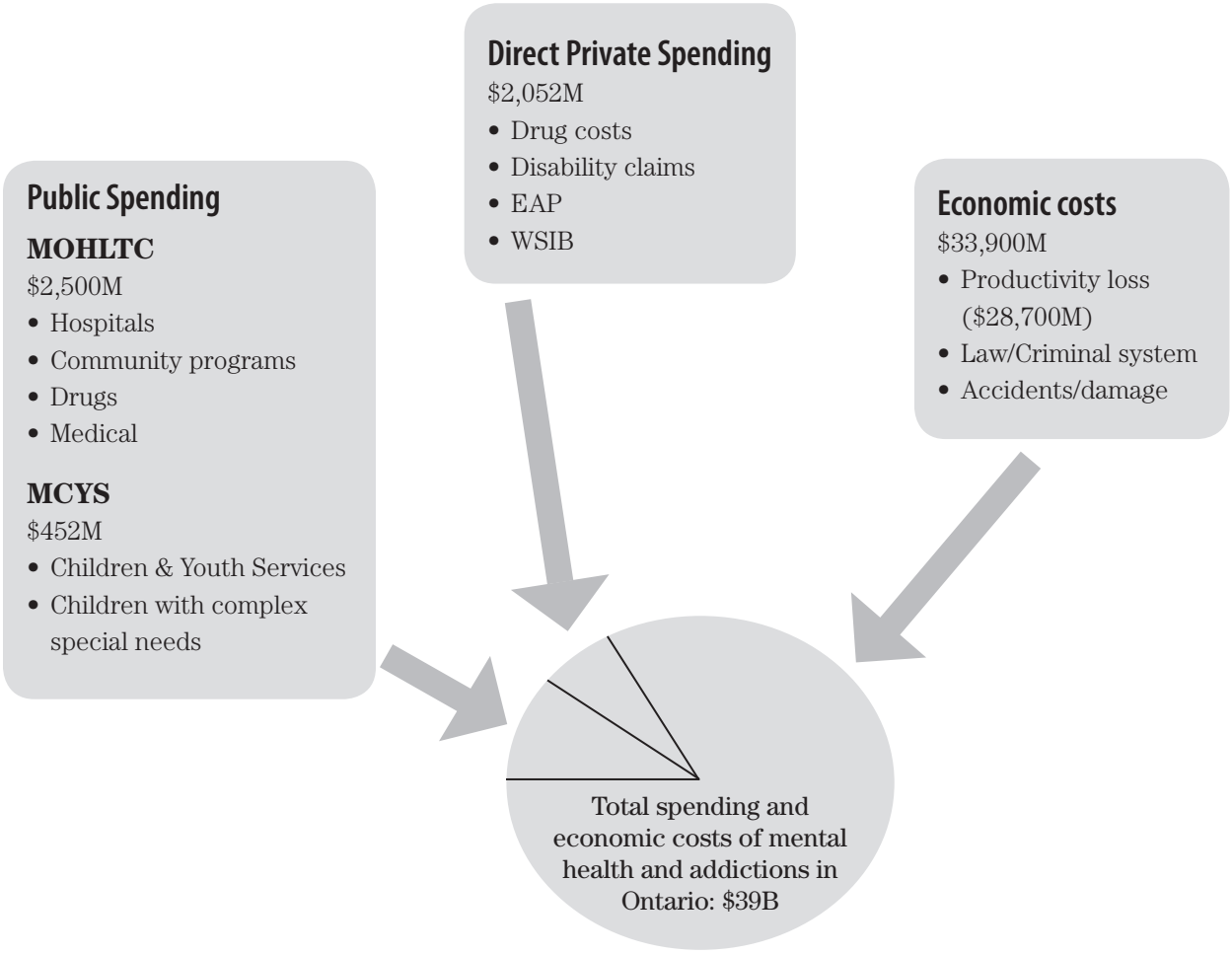
And the costs to Ontario do not stop there:

- The private sector spends at least $2.1 billion* a year on disability claims, drug costs and employee assistance programs for employees with mental health and addiction problems.
- Mental health disability claims (especially depression) have overtaken cardiovascular disease as the fastest growing category of disability costs in Canada.[19]
- Mental health and addictions cost Ontario another $2.3 billion in law enforcement services.[20]
- In 2000, mental illnesses and addictions cost society almost $29 billion in lost productivity.[21] In 2009, the amount is even higher.

Figure 2 shows the amount Ontario spent on mental illnesses and addictions in 2007.[22] [23] [24] In total, mental illnesses and addictions cost Ontario at least $39 billion a year – *not* including the overwhelming emotional costs to people with lived experience and their families and friends that we simply cannot measure.

* Private sector spending is only an estimate.

Figure 2: The Cost of Mental Health and Addictions in Ontario



*Private spending data are 2007, MOHLTC spending is 2007-2008, MCYS costs are 2008-2009, economic costs are 2001. Total spending does not include all indirect private spending (e.g., psychologists, private institutions, other).

Investing in mental health and well-being can save money

The cost of preventing and treating mental illnesses and addictions is only a fraction of what these illnesses cost society in lost productivity and other social costs. In fact, investing in actively supporting people to stay mentally healthy saves money. Every $1 spent on mental health and addictions saves $7 in health costs and $30 dollars in lost productivity and social costs.

II. Can Services Do a Better Job of Meeting People's Needs?

There is no health without mental health. Despite the efforts of many skilled providers and the current level of spending on mental health and addiction services, Ontario can do better.

Only one-third of people with a mental illness or addiction seek help

"Very few people actually ask for help.
Listening to others who have recovered showed me there is another way."

The pain and suffering caused by mental illnesses and addictions is complicated by the fact that many people and families suffer alone and do not seek help – even though services are available. Although one in five Ontarians will have a mental illness or addiction, only one-third access services.[25] About 75% of children with mental health disorders do not receive specialized treatment.[26] The gap between the people who could benefit from services and those who use them is due to four factors:

- The system does not always actively reach out to people who may need services. We usually wait for people to ask for help.
- Mental illnesses and addiction problems are largely silent and isolating. The stigma of mental illness and addiction keeps many people from asking for help.
- Many people do not recognize the signs or symptoms of mental illnesses or addictions, so they don't ask for help.
- Most people do not know where to get help.

When Ontarians do seek help, they try many different doors

"People experiencing mental health or addiction issues often quietly ask for help. As a care provider, you sometimes have to listen very carefully to hear what someone is telling you. They may not ask for help directly or walk through the door of the office that provides them with the service that they need. The whispers for help may be seen, not heard; a child falling asleep in school, an elderly woman admitted to a hospital for dehydration, the teen that just doesn't 'fit in', or the man caught breaking into cars."

Some people with mild symptoms of mental illness or addiction are able to function in society – and fulfill their roles as child, parent, spouse, friend, worker, employer and active member of their community. Others with more moderate and severe symptoms of mental illness or addiction gradually have their ability to function and to relate to others stolen from them. They may develop physical health problems, like the inability to sleep. They may struggle in school, or become isolated from their families and friends. They may lose their homes or their jobs. They may come into conflict with the law.

When people with a mental illness or an addiction do seek help, they do not necessarily knock first on the doors of formal mental health or addiction services – or even on doors to the health care system. They may, instead, look for someone who can help them do better in school, be a better parent, deal

with problems at work, or find income support, affordable housing or a job. Depending on which doors people go through, their mental health and addiction needs may not be recognized. Certain doors may not connect to the right services or referrals, and people often have to knock on many different doors to meet their health and social needs. Some doors are inappropriate. For example, some people with mental illnesses and/or addictions end up in conflict or crisis, and enter the system through police custody, the criminal justice system or correctional facilities. These should be the last doors people take to mental health and addiction services. By the time people are in conflict with the law, they, their families and friends and their communities have already suffered too much.

Ontarians should be more actively engaged in their recovery

"What helps people experiencing mental illness or addiction the most? Being heard and being offered the service that best reflects their current and immediate needs."

For mental health and addiction services to be effective, people with a mental illness or addiction must be active in their own recovery: setting their own goals or making informed choices about the services and supports they need. While many mental health and addiction services are person-centred, the lived experience of people with a mental illness and/or an addiction is not always valued or respected. Programs are often designed to meet providers' needs rather than the needs of people who use services (e.g., hours of operation, how appointments are scheduled).

Sometimes people are expected to follow a pre-set path through treatment programs. They may not be offered a range of evidence-based, culturally competent services, or supported in choosing the services they think are best for them.

Can care be more proactive?

The mental health and addiction system serves mainly individuals who reach services – rather than everyone who may need help. Many services are reactive rather than proactive. They focus on treating illnesses, rather than promoting mental health for the entire population or preventing relapses or recurrences. To improve Ontarians' mental health, the system must be able to identify people who need services, provide ongoing support and monitoring, and make it easy for people to enter or re-enter the system. At the same time, it must take a population-based approach, supporting all Ontarians to stay healthy and helping them build resilience and coping skills.

> Providers are often not able to monitor whether people actually follow through on a referral. Clients often need more support to take the next step. A passive approach is not enough.

Services can be more integrated and accessible

"The system should fit the person, not the other way around."

Wait times for some mental health and addictions services vary by region. In some cases, services are not available near where people live and work – particularly for Ontarians who live outside large urban centres – or the services do not meet the needs of our diverse population. In others cases, eligibility requirements are too rigid. For example, some mental health services require people to be addiction-free before they can access services, and some addiction services will not provide treatment or support for people with serious mental illness.

The traditional mental health and addiction system consists of a fairly narrow range of specialized services – community mental health services, substance abuse and problem gambling services and hospital-based psychiatric services – that are quite separate from other health services, such as family health care and long-term care. As a result, some people receive services that are more intensive than they need while others receive services that are inadequate for their needs.

People slip through the cracks because services are not integrated. For example:

People's mental health and addiction needs are affected by age, language, gender, race, migration, sexual orientation, culture and geographic location. Existing services and supports do not always meet our population's diverse needs.

- Mental health services and addiction services are planned and delivered separately and often have different eligibility requirements, making it very difficult for Ontarians who have a mental illness, an addiction or both to get integrated care.
- Mental health services for children and youth are not integrated with adult mental health and addiction services. This becomes a serious problem for young people as they grow up. Often people who qualified for services in the youth system are not eligible for services in the adult system.
- Mental health and addiction services are not well integrated with the other health services such as family health care, home care, long-term care services, infectious diseases and chronic disease management.
- Mental health and addiction services are not well integrated with social services people may need, such as education, employment programs, income support, parenting programs, and housing programs.
- The many different services both within and outside the health care system do not have an effective way to share information, so people with lived experience have to "repeat their story" again and again each time they access a different service. Many dedicated people work in the system, but they may not have the data, information systems and resources they need to help people move seamlessly from one setting or provider to another, or to improve the quality and effectiveness of their services.

Because of the lack of integration, Ontarians face barriers trying to move between services or change their level of service – such as youth making the transition to the adult mental health system, people trying to step down from intensive services to case management, people with addictions shifting from residential services to community treatment, and forensic clients trying to reintegrate back into the community.

Many struggle to get the right level of care from the right provider at the right time to meet their needs and help them regain their lives.

How can services reflect the long-term, changing nature of mental illnesses and addictions?

Many people have long-term mental illnesses and/or addictions. At times, they will cope well with their problem and at other times, they will need intensive services. Some addiction services – particularly residential treatment programs – are not structured to provide ongoing monitoring and support. They tend to be short-term and episodic: people are in treatment for a short period of time and then

discharged. If people relapse, there is no easy way for them to come back into the system or access less intensive services that could meet their needs.

Mental health services do provide ongoing care and support, but they do not make it easy for people who are coping well to shift, for example, from a high intensity service like Assertive Community Treatment to less intensive case management services or vice versa.

Does the mental health and addictions workforce have the capacity to meet growing, changing needs?

With the growing demand for mental health and addiction services, the workforce is hard pressed to meet needs. With the increasing diversity of Ontario's population, front-line workers are also struggling to provide culturally competent and age-appropriate care for all clients, and to work in new models of care. The work is challenging, and the roles and competencies required in community mental health and addiction services are not well defined. As a result, the system struggles to develop a workforce with the right mix and distribution of skills and to attract more people to the field.

At the same time, Ontario is not taking full advantage of the knowledge and skills of the existing workforce or of people with lived experience of mental illnesses and addiction and their families.

Stigma keeps people from seeking and providing help

Stigma keeps mental illness and addiction silent and hidden, and people with lived experience and their families marginalized and powerless. It has a devastating effect on the health and well-being of people with mental illness and/or addiction because it affects whether they seek treatment, take prescribed medication, and follow treatment plans.[27] For seniors, the stigma associated with loss of mental functioning often prevents them from accessing services, leaving them in unnecessary and dangerous isolation.

The structure of mental health and addiction services – which are quite separate from the rest of the health care system – may perpetuate stigma by reinforcing that mental illness and addictions are "different" and somehow more shameful than other health problems.

Discrimination also has a powerful influence on a person's sense of identity and affects the way the individual is viewed and views him or herself.[28] People who experience stigma can internalize it, and develop a sense of self-blame, which can lead to helplessness and hopelessness.[29] According to the New Zealand report, *Fighting Shadows*,[30] self-stigma can have a greater negative impact on an individual's health and well-being than societal stigma alone. People who have internalized stigma are more isolated, alienated, and socially withdrawn than those who do not suffer from self-stigma.

Workplace policies and practices that do not accommodate people with mental illness or addiction lead to structural discrimination in employment. Discrimination also limits people's access to affordable housing and ability to be part of the wider community.[31]

Beyond health care

"A home, a job and a friend."

Unemployment is associated with isolation and despair and job insecurity increases stress and anxiety.

The social determinants of health – education, employment, income and housing – are strongly correlated with mental health because they affect people's sense of competence and control: of being connected to the community as well as their socio-economic status. People with lived experience of a mental illness and/or an addiction often describe these determinants as "a home, a job and a friend." These social determinants of health influence people's ability to cope with their environment, satisfy needs, and identify and achieve their goals.[32]

Despite the impact that "upstream" factors have on health and well-being, the broader health system has traditionally focused on "fixing" the individual and the family, rather than creating supportive communities that provide the determinants of health, and promote both physical and mental health and well-being.

III. Transforming Services: Can We Make Every Door the Right Door?

Services and the system can change

"What gives me hope is knowing that I have not fundamentally changed because of this illness: that people still see me before they see my illness. It also helps knowing I'm not alone. My experience is a common one – a shared experience. If there are enough of us, there is hope we can change the system."

With the right mix of integrated, evidence-based services and supports, mental illnesses and addictions can be treated and – in many cases – they can be prevented. People can recover. They can regain hope and joy in life, and lead fulfilling lives in their communities.

We know what works and we're learning more all the time

"...we become part of the solution by providing an effective piece of the puzzle that has the proven potential of saving and helping to rebuild that life! That is what responsible and accountable healthy societies do...they build and wrap their support around new proven systems as the old ones continue to falter, sputter and often fail."

Ontario has been working to identify best practices in treating and supporting people with mental illnesses and addictions. We are making progress. Over the past few years, there have been significant developments in treatments for mental illnesses and addictions. Beginning in 2004, the Ministry of Health and Long-Term Care used Health Accord funding to expand key community mental health programs, such as intensive case management, assertive community treatment, crisis intervention and early psychosis intervention. In 2005 and 2006, the ministry partnered with the Ministries of Community and Social Services, Community Safety and Correctional Services, Attorney General and Children and Youth Services on the Service Enhancement Initiative to keep people with serious mental illness out of the criminal justice and corrections systems by investing in court support programs, intensive case management, crisis intervention, supportive housing and safe beds.

We have dedicated professionals and workers, and a system that wants to be evidence-based and provide the best possible services. Innovative, effective mental health and addiction programs are being developed. Many are already in place across the province. But there is still more to do. We must do more to ensure all Ontarians with mental illnesses and addictions, their family and friends, and our communities benefit from what we know, and receive more integrated services.

The next step is to develop and implement a provincial mental health and addictions strategy for all Ontarians of all ages that builds on Ontario's policy direction, including *A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health,* and Ontario's Poverty Reduction Strategy.

Vision

Every Ontarian enjoys good health and well-being, and Ontarians with mild to complex mental illness and/or addiction live and participate in welcoming, supportive communities

Mission

Every Door is the Right Door for Ontarians with mental illnesses and addictions.

All doors in the mental health and addiction system and the broader health, children and youth, education, social services, housing, seniors services, settlement services and justice systems lead to integrated, accessible, person-directed services and supports.

Services focus on the hopes and needs of people with mental illness and/or addictions, and engage them in their own health and care.

Goals

- Improve health and well-being for all Ontarians.
- Reduce incidence of mental illnesses and addictions.
- Identify mental illnesses and addictions early and intervene appropriately.
- Provide high quality, effective, integrated, culturally competent, person-directed services and supports for Ontarians with mild to complex symptoms of mental illnesses and/or addictions and their families.

Principles

Respect

People with lived experience of a mental illness and/or addiction are valued and respected members of their communities. They are treated with dignity and have access to the information they need to make informed decisions about their own treatment and services. They are active members of their treatment and support team. Health and social services are provided in the environment the individual considers to be the least restrictive, intrusive and stigmatizing. Communities and services are proactively engaged in activities designed to eliminate stigma and discrimination.

Diversity

Individuals are offered culturally competent services that meet the needs of a diverse population at all ages and stages of life.

Ontarians and their Government believe that the health system should be guided by a commitment to equity and respect for diversity in communities in service to the people of Ontario, and respect the requirements of the French Languages Services Act in serving Ontario's French-speaking community.

Ontario also recognizes the diversity of Aboriginal communities and has a responsibility to ensure its Aboriginal peoples, including First Nations, Inuit and Métis, have access to opportunities for health and to health services.

Partnership and Collaboration

People with lived experience are essential partners in system design, policy development, and program and service provision. People with lived experience, families, family organizations, service providers, governments, and the community collaborate to raise awareness about mental health and addiction services and improve knowledge about mental illnesses and addictions. All levels of government and services collaborate to provide seamless and integrated care – and make every door the right door.

Healthy Development, Hope and Recovery

Individuals using mental health and addiction services feel hope and optimism about the future. They have real choice in the services they use, and a variety of options close to where they live whenever possible. They receive the least intrusive services possible in the least intrusive setting, as well as flexible, individualized supports that involve their families, significant others, and communities when desired. They have opportunities for healthy development and recovery.

Harm Reduction

Individuals are supported regardless of where they are in their journey to reduce the health, economic and social harms associated with mental illnesses, problematic substance use and harmful gambling.

Excellence and Innovation

The mental health and addiction system strives for excellence and encourages best practices and innovation. It provides an effective, efficient continuum of high quality care that is evidence-based and results-oriented.

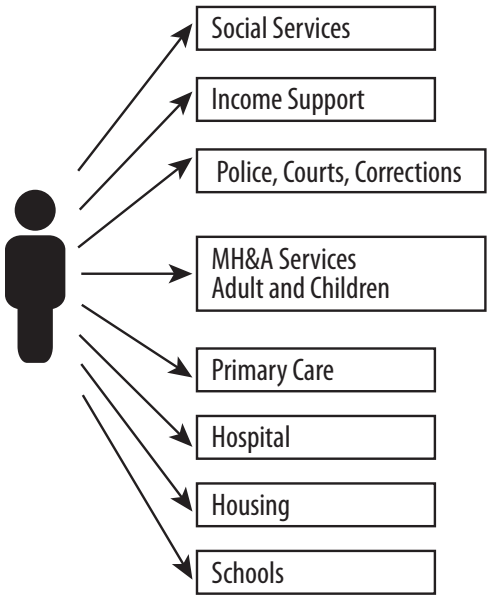
Determinants of Health and Well-being

Mental and physical health and well-being is more than just the state of one's health. In addition to caring for mind and body, the system works to reduce or eliminate the underlying individual and social factors that contribute to mental illness and addiction.

Desired Outcome

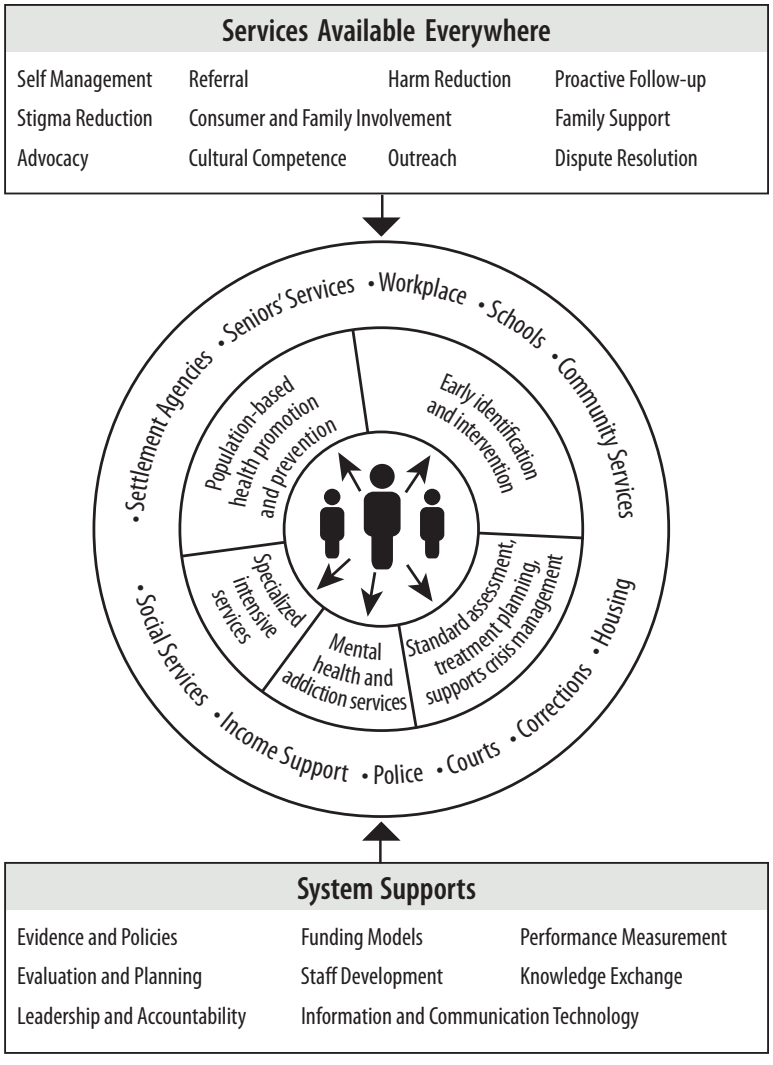
Where We Are Now

Right now, Ontario has a fragmented system of services. People go through too many doors and struggle finding the services they need. In most cases, services are not integrated. They do not work together to meet people's needs.



Where do we want to be?

We want to transform all the services that people with mental illnesses and addictions use into an integrated, person-directed system where they will have real choice and get the type and mix of services they need, when they need it. In the re-designed system every door is the right door: all doors can link Ontarians to services. In the proposed approach, the person and his or her family and friends (if desired) will be at the centre of the system. As much as possible, people will direct their own care and support, be involved in planning for their recovery and in selecting the services they use. In all cases, people can receive the least intrusive care in the least intrusive setting.



In the proposed service model, Ontarians can have access to a range of health services (i.e., the inner circle) as well as a range of social, education, employment and housing services and supports (i.e., the outer circle). The mix of services that people use can vary depending on the severity and complexity of their needs. Some services (see top box) can be available in all parts of the continuum of health services; others can be unique to certain services or settings.

The continuum of health services (i.e., the inner circle) would include:

Population-based health promotion and prevention *services include education, policy and community development initiatives that promote healthy lifestyles and prevent mental illnesses and addictions. These services – offered by all parts of the health system and all other sectors – help all Ontarians build resilience and cope with stress.*

Early identification and intervention *services include information, screening programs, family health care services, brief interventions, family support, relapse/recurrence prevention and/or referrals. These services – offered by all parts of the health system and all other sectors – help Ontarians at risk or those with early symptoms of mental illness or addiction.*

In the proposed model:

- People enter the system at different points and move quickly to the services that best meet their needs.
- People move easily between services and settings, stepping up or down in service intensity, receiving ongoing monitoring and support, according to their needs.
- Different organizations and settings can provide functions that cross intensities of services.
- Settings can also develop special programs to address the unique needs of different communities.

Standardized assessment, treatment planning, supports, and crisis management *services include assessments, brief crisis services, transitional case management, supportive counselling, withdrawal management, peer support and self-help groups, needle exchange programs, and education programs. These services – offered by family health providers, peers, community-based mental health and addiction services, child and youth services, home care and long-term care services – can help Ontarians with a mental illness and/or addiction manage symptoms and reduce risk. They are also a doorway to more or less intensive services, depending on the person's needs and wishes.*

Mental health and addiction treatment services *include consultation, residential addiction programs, services for people with concurrent disorders and co-occurring health problems (e.g., hepatitis C and/or HIV), housing support services, early psychosis intervention, and case management programs. These services – usually provided by people with specialized mental health and addiction skills working in community settings – help Ontarians with moderate to severe symptoms of mental illness and addiction.*

Specialized, intensive, services *include assertive community treatment teams, eating disorders, medical withdrawal services, psychiatric inpatient services, forensic services and other tertiary care. These services – provided by people with specialized mental health and addiction skills working in hospital settings – help the small number of Ontarians with severe and complex symptoms of mental illnesses and addictions.*

To make the system work for people with lived experience and their families, functions must be coordinated and services must respond effectively to the full spectrum of acute and longer term, ongoing needs.[33] In the proposed model, Ontarians should be able to move easily from one level of

service to another or access more than one level at the same time, depending on their needs. For example, a person may be managed by his or her family physician, in consultation with a mental health or addiction specialist, and occasionally need more intensive services, such as a short in-patient stay. The same person may also access Early Years Centres and participate in other programs to build resilience.

In this model, age will not be a barrier to care. Special efforts can be made to ease transitions between age-specific services.

The proposed model provides a way to make the best use of all skills and services. It should improve access, quality and capacity. A similar model has been proposed at the national level,[34] and is being used internationally.[35] [36]

What will it take to make every door the right door?

Our proposed approach focuses on seven areas:

1. **Act Early:** Identify mental health and addiction problems early and intervene appropriately.
2. **Meet People on Their Terms:** Develop a range of evidence-based, person-directed services.
3. **Transform the System:** Provide fast, equitable access to a seamless system of comprehensive, effective, efficient, proactive and population-based services and supports.
4. **Strengthen the Mental Health and Addictions Workforce:** Ensure we have the right people with the right skills in the right places.
5. **Stop Stigma:** Bring mental illness and addiction out from behind closed doors.
6. **Create Healthy Communities:** Fostering supportive communities is a shared responsibility that requires the commitment of all segments of society and cooperation of all government ministries.
7. **Build Community Resilience:** Take a strengths-based approach to protect people from mental illness and addictions.

The proposed model includes:

- universal mental health promotion and mental illness and addiction prevention services for all Ontarians
- targeted prevention services that directly address the risk factors for mental illness and addictions
- health promotion and prevention services for people with mental illness alone, addictions alone, and integrated mental illness and addictions, and for people with emerging problems
- treatment services for people with mental illnesses, addictions, co-occurring disorders and dual diagnoses
- appropriate services and supports for people living with mental illness and/or addiction problems and their families/friends
- ongoing monitoring and services to prevent relapse or recurrence.

1. Act Early

Identify mental health and addiction problems early and intervene appropriately

Tara, who lived in Sault Ste. Marie, was 13 when she first started having symptoms of schizophrenia. By the end of grade 9, Tara started having hallucinations, which she described as sounding like murmuring in a crowd. She began to hear singular voices, and even screaming. Tara's mother contacted a family friend, a psychologist, who referred them to an early intervention program in London: one of the first of its kind in Canada.

Although Tara lived outside the program's catchment area, the physician in charge agreed to help her. He reassured that "nothing has to change." As Tara said, "I don't have to let this limit what I want to do with my life. It's a hump, it's a hurdle, it's something to deal with, but I'll have lots of help."

She found the early intervention program very helpful. Her first impressions were that it was friendly, and there were a lot of young people that worked there, which was important. The staff interacted with her as a whole person, and Tara could relate to them. "In the early days it was the general attitude that helped the most. [I realized that] you don't have to compromise what you want for other people, and you don't have to give up on what you want in your life."

After two years in the program, Tara had most of her symptoms under control with drug therapy. However, in Sault Ste. Marie, she struggled to find support. There were no youth-driven local programs. When she went to university in London, she started a youth-driven peer program with the support of a local early psychosis intervention program: the first early intervention peer support group of its kind.

Should We Open More Doors to Support, and Open Them Earlier?

People experiencing mental illness or addiction often go about asking for help by presenting to their family physician. I think what helps them the most is for their primary care givers to be part of a collaborative care environment.

The early stages of a mental illness or addiction can create enormous stress for the person and family. Acting early – at the first signs of mental illness or addiction – can have a profound effect on the person's long-term mental health and well-being. Providing services and supports early and quickly can stop an addiction problem – before it does too much harm to the person, his or her family and friends, or society. Acting early can also prevent future episodes of mental illness, and reduce the health, social and economic costs of mental illness and addictions.

Health Canada suggests that community-based professionals are essential in identifying and facilitating access to supports and services for individuals at risk of or experiencing mental illnesses or addiction.[37] [38] Right now, many people experiencing stress may turn to family members, family health providers, teachers or workplace programs. All the places where people already go for support must be able to help or refer. We see an Ontario where every door is the right door: where a wide range of people and places – individuals themselves, family members, peers, family health providers, schools,

workplaces, and community services – are able to identify the signs of mental illness and addiction, and intervene or refer appropriately.

Key Settings for Early Identification and Intervention

- Family health care services
- Community health services
- Complementary health care providers (e.g., naturopaths)
- Schools
- Workplaces
- Seniors services
- Settlement agencies
- Pharmacists
- Emergency departments and emergency medical services
- Social assistance providers
- Municipal social services providers
- Homeless shelters
- Violence against women programs and shelters
- Needle exchange workers
- Police services
- Justice system
- Corrections

1.1 Help Ontarians self-identify and manage their health

All Ontarians should know the signs and symptoms of mental illnesses and addictions so they are aware when they or someone close to them may be at risk. They should know the steps to take to reduce their risk, such as exercise, meditation, proper nutrition, spending time with friends and family, and other ways to manage stress. They should also know when self-management isn't enough and where to go for help.

1.2 Build strong collaboration between family health providers and mental health and addiction services

While many people with mental illness and/or addictions may not seek help for these problems, they do see family health providers for other health reasons.[39] During those visits, family health providers have the opportunity to promote mental health, screen for signs of mental illness or addiction, identify people at risk, provide supports, and make the appropriate referrals. For family doctors and other family health providers to fulfill their role in early identification and early intervention, they need education, information on services and supports, and new ways to collaborate with community mental health and addictions providers and people with lived experience.[40]

1.3 Build strong collaboration between mental health and addiction services and child and youth services

The people who are already working with children and youth such as parents, teachers, community service providers, child care providers, recreation program workers, children's aid workers and probation officers, are in a strong position to identify problems early and provide appropriate interventions. For example, Student Support Leadership, a joint initiative between the ministries of Children and Youth Services and Education is designed to enhance partnerships between school boards and community mental health agencies and give students quicker access to appropriate services.

1.4 Recognize the important role of peer-based programs in early identification

Peers, self-help programs and peer-led initiatives can help identify people with a mental illness and/or addiction, and provide inspiration, guidance and information on mental health and addiction services. They can also fill a gap in the system by providing meaningful support for people who are not yet ready to enter a treatment program or who are on waiting lists for specialized services.[41]

1.5 Build stronger links with other sectors, including social services, education, employment, seniors' services, housing, settlement services, labour and justice

Many people working in other sectors are already collaborating to develop better services for people with mental illnesses and addictions, such as the court diversion programs funded by the Ministry of Health and Long-Term Care, the mental health courts and programs operated through the Ministry of the Attorney General, the addiction services initiative offered by Ontario Works partnering with local addiction agencies, the parenting support programs provided by social services, supportive housing services, and the programs for seniors offered in community and long-term care settings and through home care and hospitals. People working in these other sectors need ongoing education and information about community services and supports.

2. How Can We Meet People on Their Terms?

Develop a range of evidence-based, person-directed services

Henry's childhood was filled with war, poverty and family separation. Upon arriving in Canada at the age of 12, he worked hard to help his family, fit into his new life, and be successful. He was successful in his career as a health care professional and raising a family with his wife. However, when he faced personal life challenges, he became obsessed with work, drank heavily and played hard. Sometimes life was a roller coaster.

After Henry retired, obsession and fear grew from idleness and boredom. He became depressed, drank heavily and gambled. This led to lying about casino trips and staying longer than the intended time. This behaviour was unacceptable to his wife and strained their relationship.

The first step to Henry's recovery was acknowledging he had a problem. He found the Gamblers Anonymous (GA) and Alcoholics Anonymous (AA) programs on the Internet. Henry says, "It's a family disease so my wife and I went to GA and AA as well as a psychiatrist and drug and alcohol assessment centre for counselling. When I tried to get into residential treatment, the waiting list was years unless I paid myself. During this time, I was lying and manipulating to drink and gamble. Then I lost my license for drunk driving. During a drinking bout, I had an altercation with a neighbour. I was charged with assault and spent a night in jail."

"My fear increased at the thought of losing my wife and family. I paid for the residential treatment. At 68 years old, I changed my attitude. I had time to think about what I was grateful for and wanted to keep. I learned about the importance of structured activities, nutrition, exercise and group therapy. I had to be ready before I could accept help: honest,

open-minded and willing. It's about changing your attitude and living one day at a time to make life manageable."

Henry had a network of people supporting his recovery: his friends at GA and AA, community workers at a recovery house and aftercare, and his parole officer. His wife was willing to learn about the illness and went to counselling too. Henry and his wife have stayed involved in the programs. Henry volunteers at the recovery house and detox to let others know there's hope.

When asked what would have made things better, he said, "Some help in adjusting to life in Canada and feeling comfortable with myself. Counselling to learn about work-life balance and coping with fear. If I had known about and participated in community treatment programs or immediately been admitted into the residential program with full coverage when I asked for help, I would not have suffered so much."

Helping people choose their own doors

"Sometimes it seems they have been to a lot of other places, they have been asking and no one listened. I make a point of always listening to what the person is looking for, not assuming."

People with lived experience of a mental illness or addiction bring their strengths, wisdom, and resilience to their care and – whenever possible – must have a voice and the opportunity to make informed decisions about their care and support. The system, in turn, must provide a range of evidence-based services to support their recovery.

Person-directed care is effective.[42] [43] People who receive person-directed care:

- are more satisfied with their care
- feel more empowered
- have fewer symptoms
- require fewer tests
- have more trust in their providers and the system.

When people have a voice and choice, they are more likely to adhere to their medications.[44] They are also likely to report better quality of life.[45]

In a person-directed approach, people with mental illnesses or addictions are given the information they need to make informed choices about their care and support. When clients are not ready to make their own choices, providers give advice and guidance until the person is ready.

Over the past decade, the health sector has made concerted efforts to become more person-directed. For example, some mental health and addiction providers now work with clients, using a common needs assessment to develop individual service plans that take into account each person's goals and aspirations. Needle exchange programs across the province help people who inject drugs to reduce the harm associated with their substance use.

To provide a range of evidence-based, person-directed services, the people who use services and those who provide them must develop new ways of working together.

2.1 Build stronger partnerships between people who use services and service providers

When people with mental illnesses and/or addictions and their families (if desired) are empowered to make informed choices, they become partners in their care. To forge true

partnerships between the users and providers services, it is important to recognize the strengths, skills and knowledge that both bring to the relationship, including the provider's clinical expertise and training and the person's and family's lived experience. It is also important to recognize and overcome barriers to partnerships, such as power imbalances, stigma and lack of culturally competent services.

Families play a key role in making informed choices for children and youth. Family and friends may also be part of adults' service planning and decision-making, if desired.

When people with lived experience and their families become active partners in their care, the providers' role shifts and changes. The provider guides and supports people as they develop their service plans, and provides the information and support they need to make informed choices whenever possible – as well as the clinical services they need.

2.2 Respect and value diversity of experiences and needs

Some individuals and groups – because of ethnicity and culture, age, income, geography, education, power imbalances and other factors – may have more difficulty accessing mental health and addiction services than other Ontarians. Everyone should have the same opportunity to enjoy health and well-being. To reduce health disparities, services must develop the capacity to provide relevant, culturally-competent services for First Nations, Inuit and Métis, and for recent immigrants.

2.3 Develop a range of person-directed approaches

"It is wonderful to see people moving forward with their goals in a collaborative and recovery-based approach."

Person-directed services have the potential to transform the mental health and addiction system and develop new approaches to care and support. The system can continue to offer patients the hospital-based assessment, treatment and case management services provided by psychiatrists, physicians, nurses, psychologists and social workers – including the biomedical services and medications that are vital when people are ill. In addition, the system can integrate other evidence-based, person-directed approaches to care, including healthy development, psychosocial rehabilitation, recovery, harm reduction and trauma-informed services.

A ***healthy development approach*** includes a strong focus on early childhood development and healthy development throughout childhood and adolescence, which is key to long-term mental health. This approach is used successfully in Ministry of Children and Youth programs, such as the Early Years Centres and Healthy Babies Healthy Children, which gives all parents of young children education about parenting and healthy child development. The Early Childhood Development Addiction Initiative (ECDAI) supported by the Ministry of Health and Long-Term Care reaches out to women with problematic substance use who are pregnant or have young children. The ECDAI provides parenting supports as well as addiction treatment services. It also works closely with the Children's Aid Societies and Early Years Centres to remove a key barrier to women seeking help with addictions: the fear that their children will be taken into care.

Psychosocial rehabilitation is the process of helping someone diagnosed with a psychiatric problem re-establish normal roles and re-integrate into community life. It includes rehabilitation

work by psychiatrists, psychologists and social workers. These services include pharmacologic treatment, independent living and social skills training, psychological support to clients and their families, housing, vocational rehabilitation, social support, and access to leisure activities. Psychosocial rehabilitation helps people develop personal support networks, and encourages them to be involved in community activities, such as school and work.

The ***recovery*** approach looks at the whole person and defines the person positively, focusing on their strengths and goals, rather than their illness. Recovery is a personal journey, a social process, and (along with harm reduction) a driver to fundamentally transform the existing mental health and addictions system.[46] The goal is to help people with a mental illness and/or an addiction gain or regain their role in society. The recovery approach emphasizes: self-determination and self-management to attain personal fulfillment,[47] meaningful social and occupational roles and relationships within the community,[48] and measuring outcomes in terms of housing, education, employment and participation – not just reducing symptoms.

The recovery approach changes the role of the service provider from "expert" to "coach" or "partner", and the role of the person from "patient" to "partner" in the journey towards recovery, with the individual gradually taking more and more control over his or her progress and health.

The ***harm reduction*** approach seeks to reduce the health and social harms associated with alcohol and drug use, without requiring that users abstain.[49] For example, needle exchange programs give people who use injection drugs clean needles to reduce their risk of infection with hepatitis C or HIV. In a harm reduction approach, the extent of a person's substance use is less important than the harms resulting from that use. Although harm reduction has traditionally been used with people with addictions, it can also be applied to mental illnesses.

A significant proportion of people with mental illnesses, problematic substance use and harmful gambling – particularly women – have experienced trauma: physical and/or sexual abuse,[50] and need ***a trauma-informed approach*** to help them heal and participate more fully in life. Women who receive integrated care that includes trauma-informed practice experience significantly more reductions in mental illness symptoms and in alcohol and drug use than women in traditional services – and the cost of service is the same.[51]

3. Transform the System

Provide access to a seamless system of comprehensive, effective, efficient, proactive and population-specific services and supports

Our daughter Erynn was diagnosed with bipolar disorder, and was having violent episodes at school. When she was 10, she was hospitalized. The day before she was released, the school called us and said she couldn't come back.

Our family is fortunate in that we are well-educated, we're well-employed, and our employers understand our situation. But we had to find our own way through the system. There was no sign saying, "If your child is mentally ill, come here for services." If my child had diabetes or epilepsy, she would immediately be connected to a system of care, but that's not what happened.

The outcome is that we, and other families like us, scramble through the dark trying to find our way. We were dealing with three separate systems: child and youth, education, and health – and none were working particularly well together or separately.

Our child is thriving now. She is on the student council and getting good grades – but that's because we fought like demons, and we had to do it all ourselves. We need to stop thinking in terms of the parent coming to the system: the system should come to the parent. Instead of the teachers shuffling their feet and saying, "you may want to get your child tested," the teacher could pick up the phone to call a public health nurse, and say, "we've got a family who is having some issues," and they would get connected immediately to a system of care.

For example, if you hired a family or peer who had been through the system to keep in contact with a family waiting to get their child into treatment, it would be a big help. The connected family will walk into the next appointment way more informed and we'll have just reduced the health costs because they will move through the system faster.

We also need to really educate the family doctors. Why can't one of their mandatory continuing education courses be around child and youth mental heath? It would train them to recognize family stresses, make referrals to psychiatrists, and connect families to services and to the community of care.

Opening Doors to Comprehensive, Seamless Service

"We always need to strive to make the system more efficient. Its better than it was but we need to network with others in the field to help clients get connected to the best resource for their needs."

Right now in Ontario, only one of every three people living with a mental illness actually accesses services and supports. Some people with problematic substance use or harmful gambling may be able to manage their problem through self-help programs like Alcoholics Anonymous and Gamblers Anonymous, and may not need formal health or social services. However, many Ontarians who could benefit from these services – and regain hope – are not receiving them. In some cases the services are not available, people are unaware of the services, or the wait lists are long. The situation is worse for vulnerable populations and for people living in remote and rural communities in the north and elsewhere.[52]

Ontarians with mental illnesses and addictions need comprehensive services that meet all their health and social needs. The system must look at how services are currently organized and delivered, and find ways to make better use of all resources. Good system design can lead to better integration of services and better health.[53]

Ontario has established a number of services to help people connect quickly with care and make appropriate referrals. Through ConnexOntario, an on-line service, people can access:

- MHSIO – Mental Health Service Information Ontario that provides information on all services for adults across Ontario – 1-866-531-2600
- DART – the Drug and Alcohol Registry of Treatment that provides information as well as referrals to alcohol and drug treatment services in Ontario – 1-800-565-8603
- OPGH – the Ontario Problem Gambling Helpline that connects people with services for problem gambling – 1-888-230-3505.

3.1 Increase public awareness of mental health and addiction services and supports

Although every door should be the right door to get people to the right services, some doors are better than others. For example, family health providers – family doctors and nurse practitioners – are the first point of contact with the health system for most people. They are an efficient door because they can assess and treat some mental illnesses and addictions, make referrals, and link people to a range of other health and social services. The same is true for children and youth services and seniors' services. On the other hand, as noted earlier, the police and the court system should be last door that people go through to access mental health and addiction services.

To find the best door, Ontarians need clear, simple information about mental health, addiction and other services. They also need more services that actively reach out to people at risk, like those offered by needle exchange programs, the Early Childhood Development Addiction Initiative for pregnant women, some community detox programs, and seniors' outreach services.

3.2 Provide consistent, evidence-based innovative services across the province

All Ontarians – regardless of where they live in the province – should have access to high quality, consistent evidence-based treatments and supports. Common assessment tools and standards are already in place for some services, such as crisis intervention, withdrawal management services, and Assertive Community Treatment (ACT) Teams, and this approach is needed system-wide.

As we develop new knowledge, we must use that evidence to strengthen our programs and services. The focus on healthy development, psychosocial rehabilitation, recovery, harm reduction and trauma-informed care reflects a commitment to best practices that must be used throughout the system.

3.3 Increase capacity by using resources differently and more efficiently

The system must be redesigned to take full advantage of all resources. It must develop a continuous quality improvement culture, including finding simple ways to collect data and then using that information to redesign services. By learning more about how people move through the system, the services they use, and the providers they see, the system can see where the waits and delays are. By changing how services are provided (i.e., where, when, and by whom), the system can reduce frustration for both users and providers, and make better use of existing skills, capacity and resources.

> System redesign involves reducing or eliminating activities that add no benefit for people with lived experience. The goal is to optimize the roles and potential of all staff, find innovative ways to offer services, and support self-management.

While every door must be able to link people to the services they need, it is important to determine whether all doors add value. There may be opportunities to reduce the number of entry points to the system, leverage resources, reduce duplication, and improve access to seamless, integrated services.

3.4 Integrate mental health and addiction services with other health and social services

"We have a pretty good model…we are all under one roof. Again it's about networking and personally knowing the people you are referring to. Relationships make all the difference."

People with mental illnesses and/or addictions would benefit from having mental health and addiction services more integrated with family health care, community, hospital, crisis, social, housing, employment, education, recreational and vocational services.[54] Better collaboration and communication among services and service providers can help people get the care they need more easily and quickly. More integrated models of care also have the potential to enhance the system's capacity to address the co-morbid mental health and addiction problems that often occur with chronic medical conditions, such as diabetes, respiratory disease, cancer, and cardiovascular disease.

The shift in Ontario towards family health teams provides an opportunity to deliver mental health and addiction services in family health settings. Stronger links between the two sectors will mean more effective use of the skills of both family health providers and mental health and addiction specialists and shorter wait times for services. In places across the province where mental health and addiction providers are already working in integrated models with family health providers, capacity has increased, and the number of people served has increased.

Psychogeriatric teams made up of mental health experts, trained nurses, and outreach teams help long-term care homes provide care for the growing number of residents with dementia and aggressive behaviours.

3.5 Engage people as partners in the addiction and mental health system

People with lived experience, their families and communities have valuable skills and knowledge that can strengthen the system. When people with lived experience become partners in governing, planning, delivering and evaluating services, they can help develop effective services that meet needs. They also develop valuable skills that may help them gain work experience and participate more fully in their communities.

Peer-based initiatives across Ontario are already demonstrating their value. For example, the By Us for Us© Guides developed by a group of people with dementia help their peers develop skills to enhance their well-being and manage daily challenges.

People with lived experience also need opportunities to participate in peer-based programs, initiatives and collectives – both paid and voluntary. Peer-based services can make a significant difference.[55] People with mental illnesses who actively participate in consumer/survivor initiatives are less likely to use emergency rooms or inpatient services, more likely to report better social support and quality of life, and more likely to stay in a job or at school than those who do not.[56] Peer networking among people who use drugs improves health outcomes and reduces the harms and risks of drug use by sharing health information and providing social support.[57]

3.6 Increase capacity to detect and manage concurrent disorders

More programs across Ontario are now offering integrated treatment and support for people with both a mental illness and an addiction.[58] Because of the close link between mental health and addictions, anyone who presents to addictions services should be offered screening for mental health problems, while anyone who presents to a mental health service should be offered screening for problematic substance use and harmful gambling.[59] [60] To understand the relationship between addictions and mental health problems, a person should be assessed over a number of encounters at different points in time.[61] There is currently a pilot in the Champlain LHIN looking at the benefits of screening for concurrent disorders.

3.7 Recognize the long-term, changing nature of mental illnesses and addictions

Most mental illnesses and addictions are often long-term, enduring health problems. People with mental illnesses, problematic substance use and/or harmful gambling are often at high risk of recurrence or relapse, and need ongoing access to care and support. In the current system, people with addictions, particularly those who participate in residential programs, are treated for a short time and then discharged – despite the high risk of relapse. People with mental illnesses and addictions need a different approach to care: one that supports a number of encounters with a variety of providers over an extended period of time, offers them choices and measures success in terms of quality of life.

A number of the components of the Wagner Care Model (also known as the chronic disease prevention and management model) – including electronic reminder systems, evidence-based care pathways, case management, self-management tools, and web-based support groups and chat rooms – could be adapted for use in mental health and addiction services to provide more coordinated care and support over the long-term.[62]

3.8 Tailor services to meet local needs

Each community has unique mental health and addiction needs, depending on geography, demographics (i.e., age, ethnicity), social and economic characteristics of its population, and other factors. Local, needs-based planning can help engage the community, identify individuals and groups at high risk of mental illnesses and addictions, and tailor services to meet their needs.

In many parts of the province, this type of local planning has been an effective way to develop innovative, targeted services, such as the court diversion programs now in place for people with mental illness and mobile crisis services in some communities.

Culture, ethnicity and race influence the way people understand and communicate their mental health status, how they perceive and are perceived by mental health providers, and how they use and respond to treatments.

4. Strengthen the Mental Health and Addictions Workforce

How can we ensure that we have the right people with the right skills in the right places?

When Bob's wife developed dementia, he was fortunate that as a physician, he earned enough to be able to pay for a caregiver. He knew that the 10 to 12 hours of care per week available from the publicly funded system through the Community Care Access Centres and the community-based day program would not be enough to provide the care his wife needed and still allow him to work.

By the time he retired, Bob wasn't able to lift or move his wife on his own. He continued to use the CCAC services, but they sent different caregivers. As Bob said, "There's no consistency and, when you have someone with dementia, consistency is important."

Although he could have looked after her longer at home, when a bed became available at Baycrest long-term care facility, he accepted because "I knew if I gave it up, we would go back to the bottom of the waiting list and lose the spot."

Experiences with hospital-based care were frustrating for Bob. He explains, "good service transitions are important. When my wife was in acute care, she was not able to feed herself. But it became clear that hospital staff had not read her file – they were leaving food there for her to self-feed. These types of problems in the system are added stresses to a family that is already under significant stress due to their loved one's illness. Assigning a case manager to help the family navigate the system would make a big difference."

What worries Bob is that dementia cannot be managed in the hospital system, but there is not enough being done to manage it in the community."There needs to be resources to help people deal with their loved ones in the community as long as they can…I've been watching family caregivers and they're just worn down. We need to give them respite and relief in a way that is affordable."

According to Bob, with the aging of the baby boomer generation, dementia could be "the next tsunami for health care" and the system is not ready.

Putting skilled, knowledgeable people behind every door

People with mental illness and/or an addiction take many routes into and through the service system. The success of their journey depends on their interaction with a number of different workers, including:

- people who work or volunteer in the mental health and addiction system
- people who work in other parts of the health system, such as family health providers, community services (e.g., physiotherapy, occupational therapy), public health programs, emergency and urgent services, long-term care, other specialized treatment services (e.g., treatment for hepatitis C, HIV/AIDS)
- people who work in other social, education and justice services in the community, including income support and employment support programs, housing programs, community recreation programs,

Children's Aid Societies, schools, seniors' services, human resources and employee assistance programs, employment insurance offices, the police and correctional staff.

For people with lived experience and their families, it is extremely important that service providers be open, respectful and competent. The system must also have the capacity to connect people with lived experience with the right people with the right skills in a timely way. The mental health and addictions workforce must include people with a range of skills, experience and roles, and give them the support and tools to work efficiently and effectively.

Challenges Facing the Workforce

- clients with complex health and social needs
- large workloads
- low salaries and limited career paths
- working with clients from a variety of cultures
- keeping pace with the rapid increase in knowledge in the field, and limited funds for continuing education and training
- public stigma and misunderstanding of the nature of mental health and addiction problems

4.1 Ensure the mental health and addiction system has the capacity to meet increasing demands

A system committed to continuous quality improvement and evidence-based practice must have the infrastructure – including reliable health human resources data – to plan and support a skilled workforce. Comprehensive workforce planning should address not only an adequate supply of mental health and addiction workers, but the right mix and distribution of workers within the sector.

4.2 Develop a competency-based addiction and mental health workforce

The mental health and addiction workforce must have the skills and knowledge to provide high quality, person-directed services, including the ability to work as partners with people with lived experience and their families (if desired), and collaborate with people in other sectors. A competency-based approach – which includes defining core competencies for all roles, including peer support workers and volunteers, and valuing life experience as well as academic training – can mean better use of everyone's knowledge and skills. Providers can be able to work to their full scope, and people with lived experience can have more work opportunities. Competencies should be consistent with the sector's principles (i.e., person-directed care, the integration of clinical, healthy development, psychosocial rehabilitation, recovery, harm reduction, trauma-informed approaches to care).

4.3 Enhance the competencies of workers throughout the health and community service sector

People working in education, child and youth services, social services, housing, seniors services, justice and other sectors should be able to identify the signs and symptoms of mental illness and addiction, and intervene appropriately, referring people to the right services and providing their own services in an equitable, non-stigmatizing way. To fulfill this role, the health and community service workforce needs ongoing education and support. A more skilled, competent public workforce can mean better services for people with mental illnesses and/or addictions and more effective use of the small number of people with specialized community mental health and addiction skills.

4.4 Enhance the competencies of volunteers

The mental health and addiction field is highly dependent on volunteers, including people with lived experience and family members. Volunteers should have the training and support to fulfill their roles competently, whether that is serving on a board, working within an agency or running a peer-based program.

At a minimum, all workers providing health and community services should be able to:

- provide equitable, non-stigmatizing services to people with mental illnesses and addictions
- identify and respond to early signs of mental illness or addiction

4.5 Improve recruitment and retention

Shortages of skilled mental health and addiction workers are common across Ontario and contribute to wait lists, job stress and burnout. With the aging of the health workforce, the problem will only become worse. To improve recruitment and retention, we can address, the stigma associated with the work, and the lack of opportunities for ongoing professional development.

5. Stop Stigma

Bring Mental Illness and Addiction Out from Behind Closed Doors

Betty Lou grew up in a violent home. She left when she was 16 and, by the time she was 20, was in an abusive marriage and pregnant. She left when her son, Pete, was a toddler but she remarried almost immediately. Her second marriage, a toxic relationship, paved the way for her to become addicted to alcohol, marijuana, cocaine and prescription pills.

She wanted to be a good mother so she turned to her family doctor, but he just wasn't equipped to help her. He often sent Betty Lou to the emergency department in crisis. She was diagnosed with a number of psychiatric illnesses, from anorexia to obsessive-compulsive disorder to rapid-cycling bipolar disorder. Even when she got help – usually after a suicide attempt – it was largely piecework. There was never a coordinated effort to treat both her mental illness and addiction.

At that time, when her life was in chaos, Betty Lou met a stable man who loved her and her son – 23 years later, she is still married to the same man. Feeling safe and supported in her relationship gave her the courage and strength to begin the healing process. But just when she was taking control of her life, Pete was losing control of his. He suffered severe anxiety, panic attacks, depression and hallucinations. He began drinking to cope and became severely addicted to a prescription pain medication. He tried to get into treatment but he had to be clean before they would accept him – he couldn't even be on methadone – and he just couldn't cope with the withdrawal symptoms. On December 23, 2001, he died from an overdose.

Having lost her only child to the same illnesses she fought for most of her life, Betty Lou is now determined to prevent others from suffering the same fate. She now dedicates much of her time to keep others from following the same path.

When Betty Lou looks back on her life, she sees many times when people could have intervened and made a difference. Betty Lou also found a bias against addictions in the mental health system. It was hard to get treatment for her concurrent disorders, and she needed both mental health and addiction services to recover. She also found there was stigma and less sympathy for someone like Pete, who died because he had an addiction.

Throwing open doors to dispel misperceptions

As the Mental Health Commission of Canada has pointed out, the stigma associated with mental illness and addiction is often based on myths and misperceptions, such as:

- All people with mental illness are violent and dangerous.
- Mental illness is a single, rare disorder.
- People with mental illness or addiction are poor and less intelligent.
- Mental illness or addiction is caused by a personal weakness.

People have a poor understanding of mental illness, and they are afraid of those they perceive as mentally ill.[63] In fact, the public is more inclined now than they were a few decades ago to perceive people with mental illness as dangerous. Stigma and discrimination are not limited to older generations: young people today have less favourable attitudes than adults to mental illness and greater reluctance to seek help for mental health problems.[64]

The most effective way to reduce stigma is to increase the number of positive, face-to-face positive interactions Ontarians have with people with lived experience.

Misperceptions and stigma lead to a "blame the victim" mentality. Discriminatory language – terms such as "psycho", "lunatic", "crazy", "druggie, and "addict" – reinforces myths about mental illnesses and addictions. As a result, people living with mental illnesses and addictions are often excluded from society.

As a group, mental health and addiction professionals are no less susceptible to discriminatory beliefs than the general population. A recent study of resident physicians in a range of specialties showed that education and work experience had little effect on their attitudes towards people with mental illness and/or addictions. What does make a difference is personal experience: the doctors with the most positive attitudes were those who had family members with a psychiatric illness.[65]

To improve health for people with lived experience and their families – to create healthy, supportive communities – we must eradicate stigma and discrimination. Ontario must change attitudes and perceptions, and create a society where all people understand mental illness and addictions, and support prevention and recovery programs.

5.1 Eradicate discrimination in all publicly funded services

In terms of providing respectful services, the public sector must set an example for the rest of society. All publicly funded programs should provide supportive, stigma-free services. To change the attitudes of providers in all settings, it is important to "normalize" mental illnesses and addictions, and focus on the strengths of people with lived experience. Integrating mental health and addiction services with other health care services, including family health care, public health, home care and long-term care – can help remove the "different" or "marginal" nature of the services.

5.2 Fight self-stigma

All evidence-based approaches to treatment and support – healthy development, psychosocial rehabilitation, recovery, harm reduction and trauma-informed services – work to reinforce that mental illnesses and addiction are illnesses, and reduce self-stigma and self-blame. In the fight against self-stigma, peer support initiatives play a key role, as do opportunities to participate in meaningful ways in mental health and addiction services and in the community.

5.3 Champion respect for people with mental illnesses and addictions

"[Only when] we acknowledge the fact that this can happen to anyone and rid society of the stereotype that only individuals lacking character would succumb to such an illness, will we have the public opinion required to make this happen."

Several countries have already developed successful anti-stigma campaigns. Based on their experience, we know that it takes a concerted effort to stop stigma and discrimination, and correct misperceptions about mental illnesses and addiction. That effort must involve all members of society: people with lived experience, families, friends, neighbours, employers, educators, and service providers.

Many attitudes are shaped young, and stigma and discrimination can start early. School-based programs, such as the Ministry of Education decision to make reducing stigma part of school curriculum, can fight discrimination and create more supportive communities.

6. Create Healthy Communities

Fostering supportive communities is a shared responsibility that requires the commitment of all segments of society and cooperation of all government ministries.

When Eliana immigrated to Canada as a 24-year-old mother of four, she found life difficult. She was haunted by memories of her brother who was killed during a political crisis in Chile. She would talk to him even though she knew he could not be there. Eventually, she was admitted to the Queen Street Mental Health Hospital in crisis. Meanwhile, her husband, who was also affected by their exile from Chile, physically abused her. Eliana began to drink heavily to cope, but her mother's death pushed her over the edge. She admitted herself to the hospital, where she said she "finally felt free from the terrible situation at home."

The hospital staff realized Eliana was an abused woman, and helped her to find her own place in supportive housing. Being able to live in peace in a place of her own gave Eliana a newfound sense of control over her life. She gained the confidence to go back to school – something she never thought she could do. In 1994, she graduated with one of her sons, and felt extremely happy and proud.

Eliana decided her mission was to fight for those who are abandoned by their family and society. She became involved in the Dream Team, a peer-driven initiative. She began to advocate for people who have no place to go and for those who are abused and abandoned. In speaking for her own and others' rights, she found her own strength.

As Eliana said, "What do people need? Friends, family. Everyone needs someone to help them. Because we are all human beings, we all have problems. The key is to have sensitive people to talk to about our problems." This is how Eliana believes we can make a difference.

Opening Doors to Healthier Communities

People with lived experience should have the same opportunities as other Ontarians to have income, employment, housing, education and lifestyles that lead to better health.

To create healthy, supportive communities, we need the commitment of all segments of society: governments, employers, schools, community organizations and faith-based organizations. All ministries must work closely together, share a common understanding of the importance of the social determinants of health, and align their policies and programs.

6.1 Provide opportunities for secure and adequate income

A secure income is a key determinant of health. Low income is associated with higher rates of mental illness in children and youth.[66] A significant proportion of social assistance clients experience mental illness and/or addictions.[67]

6.2 Promote employment in supportive, inclusive workplaces

Paid work helps give people a sense of accomplishment, identity and social connectedness. A sense of control over one's work can have a powerful impact on mental health. Supportive and inclusive workplaces also make good business sense: they contribute to a healthy bottom line and a strong economy.

On the other hand, job strain, lack of decision-making power, low social support, high psychological demands, and job insecurity are risk factors for mental health problems.[68] Heavy workloads, lack of recognition at work, and conflicting home and work demands contribute to mental health problems.[69]

6.3 Promote safe housing and environments

Stable, safe, and supportive housing improves health and well-being[70] – as do safe physical environments. People with mental illnesses and addictions need access to affordable housing in well-maintained buildings as well as supports to help them find and keep their housing.

6.4 Provide opportunities for effective, flexible, relevant education

All types of mental disorders, including anxiety, decline with increasing education.[71] Education increases job and income opportunities, the ability to understand health information, and control over life – all of which are linked to better mental health. On the other hand, people with low levels of education or outdated job skills often end up trapped in low-income jobs, and stuck in the cycle of poverty, mental illness and addiction. Many people with lived experience of mental health and/or addictions as well as people at risk have had their education interrupted. Flexible, relevant, age-appropriate education programs can help people build life skills, citizenship, job readiness and life-long learning, and meet their education goals.

6.5 Promote healthy lifestyles, including self care and exercise

Leading a healthy life – getting regular exercise, eating healthy foods and taking care of one's health – can reduce stress and anxiety, and build resilience. Self-care – looking after one's health, going for regular checkups, having a healthy blood pressure, taking any medications as prescribed – helps improve overall health and well-being. Exercise increases the production of neurotransmitters in the brain associated with mood. People who exercise regularly feel better about themselves and are better able to cope with stresses in their lives.[72] Regular physical activity can decrease mild to moderate depression as well as the odds of cognitive impairment and dementia.[73]

What people eat affects their mood, behaviour, energy and brain function. The human brain requires high levels of energy and nutrients. Changes in energy or nutrient intake can alter both brain chemistry and nerve functioning in the brain, affecting sleep patterns, thinking, memory and problem-solving skills. Healthy eating is particularly important for people with problematic alcohol use because alcohol is associated with nutritional deficiencies that affect the brain. When people eat healthy foods, they are likely to feel better, have more energy and be able to think more clearly and cope better with stress.[74]

Ontarians with or at risk of a mental illness or an addiction need opportunities and support to lead healthier lives.

7. Build Community Resilience

Take a strengths-based approach to protect people from mental illness and addictions

Bradley came from a family of eight kids, mixed Native and Black, in Chatham, Ontario. He was a gifted child, and his parents encouraged him to be the best he could be. "I was a good kid," he said, "and I wanted my parents to be proud of me." When Bradley was 17, his parents got divorced. He thought it was his fault and internalized those feelings. When he moved with his mother and brothers to Detroit, Michigan during the time of the race riots in the 1960s, he started using pot and alcohol, not realizing that he was genetically pre-disposed to addiction, or the impact drug use would have on his spirit and body.

Although Bradley became financially successful as an adult, he was emotionally angry and continued to self-medicate with drugs. He started experiencing harms from his drug use, and ended up in jail. "I couldn't cope with my anger, and abuse I experienced in jail kept me in the cycle of addiction." When he came back to Canada in 1978, he discovered cocaine and got involved in criminal activity, which led to more jails and institutions. From 1986 to 2000, Bradley was homeless. "It was bad, bad, bad," he explained, "I felt helpless and hopeless. I was the walking dead".

At the age of 50, Bradley decided to change his life. He got involved in Drug Treatment Court. As he says, "Jailing people isn't a solution. People come out more angry and bitter, and more equipped to do crime. Programs like Drug Treatment Court are far better solutions."

When asked what helped him most, Bradley talked about spirituality, diet, exercise, support groups and supportive housing. "Having supportive housing was an important thing for me. [I needed] time and a safe space to get to the decisions I needed to make."

According to Bradley, it would have made a difference in his life if there had been early intervention programs for youth and if there had been more peer support. "I have a doctorate in lived experience, and I bring that experience to the table," says Bradley. "When it comes to addictions, if a person hasn't lived it, they're not going to get people to talk."

Bradley is now helping others find their way so "they too can walk with a sense of dignity and freedom that you can't get from drugs." He joined Voices from the Street, and does speaking engagements and educational workshops with CAMH, universities, the ministry of justice, social services, schools, jails, youth groups and gangs. As he says,"I work to build resilience. I have a lot of hope for my life and for the future, and my mission is to advocate for supportive housing and effect change for those who've gone through hell.... People can change their lives. If I can do it, anybody can."

Closing Doors on Risk, Opening Doors to Resilience

Services for people with lived experience tend to focus on treating their diagnosed problems – their weaknesses – rather than on their strengths. All people have strengths and resilience that they can build on – to protect their health, to reduce risk and the negative consequences of a mental illness or addiction, or to help them recover from an addiction. However, because of life circumstances, some individuals and groups may have fewer protective factors and, therefore, be at higher risk of developing a mental illness and/or addiction during their lifetime than the general population.

Mental illness and addiction are not inevitable. Communities can help build strengths such as family and friends, problem-solving skills, coping style, social skills, being optimistic and having a sense of purpose – and protect people from mental illnesses and addictions.[75]

When communities can identify people who are vulnerable, they can provide services and supports tailored to local needs that help people build strengths, participate in their communities, become more resilient and improve their health. Population-based health promotion and disease prevention programs can build community resilience.

7.1 Strengthen health and wellness promotion in communities

Health and wellness promotion programs educate people about the lifestyle choices that can improve their mental health and well-being, such as exercise, nutrition and self-care. These programs – which target whole communities as well as individual and groups at risk – are most effective when they are driven by communities and offered in local venues, such as schools, community centres, seniors' centres, shopping malls and churches. At the community level, mental health promotion seeks to build healthy environments (e.g., schools, workplaces). At a structural level it works to ensure that public policies address mental health and well-being by, for example, promoting equity and inclusion, and reducing discrimination.

Many communities across Ontario are already developing health and wellness programs and policies, such as the basketball leagues, aerobic classes and other exercise programs developed for about 400 Somali youth and their parents in Toronto as part of Ontario's Action Plan for Healthy Eating and Active Living. These programs help young people adjust to life in Ontario, engage in healthy activities and avoid activities that might put them at risk for mental health problems and addictions.

7.2 Support social inclusion through families, friends and community activities

"As we know, resiliency and the ability to move past a crisis are strongest when you are connected to family and people in your community."

Social support and good social relations – friends and family – are good for health. People who are part of social networks feel cared for, loved, esteemed, and valued. Being "part" of society – feeling included – has a protective effect on health.[76]

Participating in volunteer work, paid work and recreation activities help people feel socially included and become more resilient. Communities that provide opportunities for people to be involved and to contribute to society help nurture a healthier population and a more prosperous Ontario.

7.3 Enable communities to realize the potential of groups at risk

For those who accept the older ways of healing, most of them are choosing that along with the counselling. So they will take my counselling and they will go along and seek some of their own traditional ways. There isn't much of a difference except they choose two paths, the native path as well as the contemporary western path.

Mobilizing communities and neighbourhoods can help protect people from mental illnesses and addictions. Community development approaches are particularly important for people living in poverty who are often excluded because they do not have equitable access to education, employment or housing.[77] For example, the Aboriginal Healing and Wellness Strategy is a holistic, community-based approach to improving physical, mental, emotional, spiritual and cultural health and well-being for Aboriginal individuals, families, and communities. London, Ontario, is using a neighbourhood strategy to strengthen its community, engaging people in neighbourhoods

with risk factors (e.g., low income, high unemployment, low level of education and high rates of crime) in planning initiatives to improve their health and help them realize their potential.

Communities of interest can also be powerful forces in helping improve health and services. For example, in the 1990s, we saw the ability of families of people with schizophrenia to support one another and to shape services for people with serious mental illnesses.

IV. Supporting Frameworks

To make every door the right door for people with mental illness and/or addictions, the system must change. We must work differently, offer services in different ways, develop new skills and attitudes, and forge stronger partnerships between sectors and between service users and service providers.

To transform the system – to open existing doors and create new ones – Ontario needs the right structures and tools.

Establish Leadership, Governance and Accountability

When people talk about mental health and addictions services, they usually mean the specialized and intensive service and supports funded by the Ministries of Health and Long-term Care and Children and Youth Services. But our goal is to mobilize a much broader range of services and supports. To make every door the right door, all organizations that provide services for people who are vulnerable or have lived experience – government ministries, municipalities, community leaders, schools, family health providers, social and justice service providers, and workplaces – have a part to play in promoting mental health and well-being, and providing integrated, person-directed services.

To make this shift, these organizations need structures that make it easier for them to provide integrated services. Right now, each ministry and sector has its own definitions, protocols and eligibility criteria for services – which can open or close doors.

Identify champions

The Minister of Health and Long-Term Care, the Minister of Children and Youth Services and the Attorney General have all identified mental health and addictions as priorities and are providing leadership within government.

Develop leadership roles, structures and accountabilities

An integrated system requires clearly identified roles and responsibilities.

Streamline policies and practices

Policies across ministries/sectors need to be streamlined to help local oversight boards and service providers develop integrated services.

Develop and adopt evidence-based standards

Common standards for service design, information management, and clinical care can help improve the quality and consistency of services across the province.

We will know how we are doing in implementing the 10-year strategy by measuring key performance indicators, such as wait times for community mental health and addiction services, the experience of people using services, and the level of collaboration among service providers.

Evaluate the report publicly on outcomes

Performance measures will tell us if we've been successful. They can also help promote best practices and improve the lives of people with lived experience.

Manage Change

Creating a person-directed system – making every door the right door – means a shift in culture in mental health and addiction services, in the health system and in the broader community service systems.

Transforming the System, Transforming Lives	
Where We Are Now	**Where We Want to Be**
Prevention is overlooked	Prevention and early identification are priorities
The system helps only people who reach services	The system reaches out to the whole population and all who need help
Services focus on treatment	Services focus on healthy development, recovery and harm reduction
Care is disease or provider-centred	Care is person-driven and family-centred
People with mental illnesses and/or addictions have limited support to manage their own care	People with mental illnesses and/or addictions are empowered and supported to manage their own care
Care is reactive and episodic	Care is proactive and ongoing
Providers and programs work in isolation	Providers and programs work collaboratively
Services plan and operate in separate silos	Services are integrated and coordinated
There is a sense of isolation and frustration	There is a culture of improvement and innovation
The system uses data and measurement for reporting	The system uses data to improve services

To get to where we want to be, we must change the way we work. There must be more collaboration and fewer silos. We must make effective use of change management strategies, such as communications, information technology and implementation plans. Effective use of information technology can support and accelerate integrated services, self-care, ongoing follow-up, and the use of best practices.

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