



**CANADIAN MENTAL
HEALTH ASSOCIATION, ONTARIO**

**ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE, ONTARIO**

ADVICE TO THE MINISTER OF HEALTH AND LONG-TERM CARE:

Developing a 10-Year Mental Health and Addictions Strategy for Ontario

**Analysis of the Reports of the Minister of Health and Long-
Term Care's Advisory Group and the Select Committee of the
Legislature on Mental Health and Addictions**

February 2011

Hon. Deb Matthews
Minister of Health and Long-Term Care
80 Grosvenor Street, 10th Floor
Toronto, Ontario, M7A 2C4

Dear Minister Matthews:

It has been over 10 years since the Ontario Government released its last mental health strategy, “Making It Happen”. While much has changed and new investments have been made, there is much more to be done. Providing consumers, their families and communities with evidence-based supports for recovery in a timely manner is a complex task and requires true partnership of everyone involved.

The Auditor General’s Report of 2008 highlighted the need for further action. In 2010, the Select Committee of the Legislature spoke passionately to the need for government to respond to the devastating impacts of mental health and addictions on individuals, families and communities; impacts that can be mitigated if the will is there to do so. As well, in December 2010, your own advisory committee has provided you with strategies and recommendations on how to move forward.

The Canadian Mental Health Association has been working for almost one hundred years on improving the lives of mental health consumers and in promoting mental health for all. At CMHA, Ontario we have worked closely with the Ontario Government for five decades on a shared vision of equity, access and care for mental health consumers and their families.

We have been actively involved in the work of the Select Committee and the Minister’s Advisory Group. We have reviewed the two reports and offer some specific and targeted advice that we believe must be addressed in your new strategy. Our advice builds on the work of the reports you have before you.

This year, the release of your new mental health and addictions strategy will set the agenda for the next decade. It will impact the lives of millions of Ontarians. We all

know what needs to be done. As your Government moves forward, CMHA, Ontario is ready to help with the implementation of this extremely important strategy.

Sincerely,

A handwritten signature in black ink, appearing to read 'Tom McCarthy', with a stylized flourish at the end.

Tom McCarthy
President

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Introduction

Across Canada and internationally there is a call to action in response to the growing recognition of the human and economic burden on society that results from poor mental health and/or substance abuse. In 2010, two seminal reports that will shape Ontario's collective response were released.

In August 2010, a Select Committee of the Legislature on Mental Health and Addictions released its final report entitled, "Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians."¹ The 23 recommendations of the Select Committee were founded on their 18 months of work and were informed by 230 presenters and over 300 submissions.

In December 2010, the Government released the Report to the Minister of Health and Long Term Care from the Minister's Advisory Group (MAG) on the development of a 10-year Mental Health and Addictions Strategy. "Respect, Recovery Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy,"² represents almost two years of study and consultation on what is needed to address the needs of Ontarians living with mental illness and/or addictions.

Purpose of the Report

The Canadian Mental Health Association, Ontario (CMHA, Ontario) has reviewed the findings and recommendations of the two reports. Our intention in doing so was to look for consensus that should guide the action agenda; where differences in approaches or conclusions require resolution; and to identify gaps in the reports that should also be addressed in the Ontario Government's 10-year mental health and addictions strategy expected later this year.

Action Is Needed

Study after study has spoken to the impacts of mental health and addiction issues on society. One in five Ontarians will experience a mental illness. Every household in

¹ Select Committee on Mental Health and Addictions Final Report, "Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians," 2nd Session, 39th Parliament, 2010.

² Report to the Minister of Health and Long Term Care From the Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy, "Respect, Recovery, Resilience," December 2010.

Ontario, at some point, will be impacted by a family member, a friend, or a colleague that is experiencing a mental health and/or addiction issue. The economic costs have been estimated at \$51 billion a year in Canada and the social and human costs are far greater.

There is no lack of consensus in the two reports that action – significant action – is needed to ensure adequate capacity and ability of our mental health and addiction services system to respond to the needs of all Ontarians.

In its introduction, the Select Committee report notes that, “... *we have been changed by what we have heard, and we are now convinced that a radical transformation of mental health and addictions care is necessary if Ontarians are to get the care they need and deserve.*”

Similarly, the MAG report notes in its transmittal letter to the Minister, “*We know from our day-to-day experience how urgent the needs are – how many people are suffering – and how the current way of organizing and delivering services is failing Ontarians.*”

Ontario Is Not Alone

Ontario is not alone in addressing these crucial matters. In March 2010, CMHA, Ontario conducted a review of recent mental health strategies released by other jurisdictions³ including:

- The Government of Australia: Fourth National Mental Health Plan: An Agenda for collaborative action in mental health 2009-2014
- The State of Victoria, Australia: Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019
- The Government of England: New Horizons: A shared Vision for Mental Health
- Province of New Brunswick: Together Into the Future
- The Government of Scotland: Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011.

Australia, the UK and Scotland were included in our review as they are considered international leaders in addressing issues affecting the mental health of their population.

The strategies outlined in the two Ontario reports are generally aligned with the other jurisdictions that were studied. The visions contained in all the strategies stressed the necessity for system reform that is *predicated on a recovery-based or person-based*

³ Canadian Mental Health Association, Ontario, “The Windows of Opportunity for Mental Health Reform in Ontario,” March 2010

approach. All reports were based on the belief that the *best outcomes for those with a mental illness are contingent on a partnership between providers and consumers.* The strategies were also in agreement that the societal and economic impacts of mental illness are so substantive that money spent on mental health promotion and the prevention of mental illness (upstream actions) present significant cost-benefits when compared to the downstream costs of illness. The strategies speak to the need to invest in healthy families, early childhood, mentally healthy workplaces and the reduction of risk factors.

Other notable similarities between these strategies and the Ontario reports were found with respect to:

- the importance of resilient and supportive communities
- the need to address diversity and cultural differences
- enhanced research; and
- addressing stigma and discrimination.

Consumer Role

Consumers have an essential role in a system that is recovery-based and person-centred. The Select Committee Report identifies the benefits of involving consumers as providers of peer support; while the MAG Report also recognizes consumers as partners in service planning and delivery. CMHA, Ontario supports these recommendations but believes that the mental health and addictions services system must be designed to include the input of people with lived experience at all levels of planning, decision-making and evaluation; consumers of course, but also family members.

Of concern to CMHA, Ontario is that the role of consumer/survivor initiatives (CSIs) is not addressed in either report. CSIs offer support services, self-help groups and alternative businesses that are run by individuals with mental illness. Ontario was a recognized leader in funding CSIs to support recovery; and CSIs were considered an integral part of the mental health system.

Despite their important role in the mental health system, CSIs have not been adequately supported in their development. The MOHLTC has received advice from the ‘CSI Builder’ project on what is required in Ontario to build capacity and ensure sustainability and these recommendations should be brought forward for action.⁴ It is essential that

⁴ Ontario Federation of Community Mental Health and Addiction Programs. “Consumer Survivor Initiatives in Ontario: Building for an Equitable Future.” June 2009.

CSIs be recognized in the new mental health and addictions strategy to ensure they are provided with better support to build capacity.

Reducing Risk Factors and Responding to Individuals in Contact with the Law

There are various pathways by which individuals with mental illnesses and/or addictions are coming into contact with the policing, justice and forensic systems. As a result of some improvements in these sectors, there has been increased case-finding and the number of clients requiring services from the mental health and addictions system is increasing. Demand has exceeded available services and increasing capacity for individuals with mental health and/or addictions is urgently needed. Policing, justice, and forensic services were deemed of such importance during the consultations, that the Select Committee dedicated a full section to these issues. This is one of several inter-sectoral priorities that the mental health and addictions strategy must address. As a note of caution, investments in mental health services in this area should not be seen as an 'either/or' situation. Taking resources away from other mental health or addiction service areas to support policing, justice or forensic services will further exacerbate wait times overall.

The MAG Report also focuses on primary prevention within communities to reduce the likelihood of contact with the law. The report correctly recognizes the association between healthy, resilient, inclusive communities and access to economic resources, in reducing the cycle of poor mental health, addictions, discrimination and violence.

CMHA Ontario concurs that the 10-year strategy should detail actions to ensure that all these issues are responded to, in order to comprehensively address both the root cause; as well as service enhancements at the intersection of mental health and addictions with justice related services.

Quality of Care

Quality of care is a desirable goal of the MAG report and efforts to improve the system through quality initiatives are to be lauded. Quality improvement (QI) can impact positively on efficiency and effectiveness; however we caution decision-makers to not expect QI to resolve service issues that result from inadequate capacity to meet the needs of Ontarians.

Building System Capacity

Both Ontario reports recommend a ***basket of core services*** be identified and provided to bring additional capacity into the system. Those seeking mental health and addiction services often require an array of additional supports, such as income support and housing. Building a responsive and coordinated system to accommodate the breadth of service needs can be challenging within the current service delivery systems, which are designed on disparate ministerial, departmental and functional structures.

Access to a comprehensive range of services and supports is urgently required. The Select Committee's recommendation that 'a basket of core institutional, residential and community services is available in every region of the province' is to be commended. Ontario lacks population-based models and directions for delivering mental health and addiction services across the life span. Population-based planning and equity tools, underpinning a strategy to provide a core basket of mental health and addiction services, could alleviate inequities based on historical funding patterns that currently exist in Ontario communities. The new mental health and addictions strategy needs to ensure its policies set clear goals and targets to ensure a comprehensive core basket of mental health and addiction services are available across this province for all Ontarians.

Investments to Expand Capacity and Ensure Quality

The Need For Investment is Clear

Lack of capacity in services cannot be ignored. While the current economic climate may require a measured pace for new investments, a commitment to investment needs to be addressed in the new strategy. While neither of Ontario's reports proposes specific targets for investment to lessen service gaps; both reports do address the need for additional resources.

The Select Committee states:

"In general, Ontarians wait too long for treatment." (Page 1)

"Approximately one in ten people suffer from highly treatable, yet overlooked, conditions such as anxiety disorders. Finally, 'community support' often means that an individual is cared for by a stressed, over-burdened family struggling along without assistance." (Pages 2, 3)

The MAG report notes:

"Right now in Ontario, only one of every three adults – and one in every six children – living with a mental illness actually accesses services and supports. " (Page 31)

The Ontario Medical Association has also highlighted the need for investments. In their response to the MAG report Dr. Mark Macleod said, *“Patients with mental health and addictions and their families have been calling for improvements for far too long. With a decade of research already completed, it’s time to take action to ensure that patients have timely access to quality care.”*

Hospitals are also supportive of new investments. The recent Ontario Hospital Association’s strategic plan calls for real investments for community mental health services to increase capacity and help the system cope with needs in a more effective and appropriate way.

Specific Investment Strategies Are Required

As a capacity building strategy, the Select Committee report recommends that Ontario ensure a *“basket of core institutional, residential and community services is available in every region of the province for clients of all ages...”* (Page 7). Similarly the MAG report states that *“Ontarians with mental illnesses and addictions need timely, quality services that meet all their health and social needs.”* (Page 31)

Putting a specific number on the cost of building such capacity in the mental health and addictions services system is highly complex. That said, there is sufficient evidence that significant investments are needed to realize the reports’ goals for a consumer led, integrated, evidenced-based, high quality system of care. Ontario needs to develop and implement a multi-year investment strategy to bring our expenditures in line with international leaders.

A research study in the Canadian Journal of Psychiatry in 2008 entitled, “Expenditures on Mental Health and Addictions for Canadian Provinces”⁵ concluded that, *“Canadian public mental health spending is lower than most developed countries, and a little below the minimum acceptable amount of 5% stated by the European Mental Health Economics Network.”* The study looked at data for general hospitals, psychiatric hospitals, fee for service physicians, community mental health centres, pharmaceuticals, and addiction services.

The study showed that per capita expenditures ranged from \$230 (2003/04) in British Columbia to \$138 in Saskatchewan. While the Canadian per capita average was \$172, Ontario spent only \$152. Provincial community mental health expenditures varied from \$17 per capita to \$64 while Ontario’s expenditures were \$27 (Canadian average \$43).

⁵ Jacobs, P., Yim, R., Ohinmaa, A., Eng, K., Dewa, C., Bland, R., Block, R., Slomp, M., The Canadian Journal of Psychiatry, Vol. 53. No 5, “Expenditures on Mental Health and Addictions for Canadian Provinces in 2003/04,” May 2008

For addiction services Ontario spent \$10 per capita compared to the national average of \$13. More so, there are substantial inequities across the province. Within Ontario there is also considerable inequities depending on where a person lived. For example, in 2007, funding for community mental health services ranged from \$19 to \$123 per capita across Local Health Integration Network areas.⁶

A 2008 report by the Institute for Health Economics and Alberta Health Services researched the question, “How Much Should We Spend on Mental Health?”⁷ The report considered a number of methodologies to answer the question. The overall conclusion was that an average increase in investment of \$1.251 billion dollars was required in Canada over the next five years. Based on population distribution in Canada, this would imply that Ontario needs to invest about \$100 million per year in each of the next five years (for the basket of services noted in the report). This report was updated in 2010. The revised report moved away from specific investment recommendations. This was not because investments were not needed but simply because comparative investment data was not sufficiently robust. The report did show that in 2007/08, Ontario spent \$3.324 billion on inpatient services, physician services, community mental health services and addiction services. Only 26.6% of the expenditures were spent on the latter two community-based services.⁸

For the purposes of this report, it is not possible to independently verify the investment numbers or methodologies used in the above studies or to propose any specific dollar investments. The essential finding is that while the two reports are silent on this matter, research shows that very significant investments are needed to meet the needs of all Ontarians. While a more measured pace of investment may be dictated by the current economic climate, the gap cannot be ignored and a commitment to investment needs to be addressed in the new strategy.

Funding considerations must also determine what are the reasonable costs for programs in order to deliver services. There are already program standards for some services and additional program standards are anticipated. The effective implementation of program standards will be dependent on programs having appropriate funding to deliver programs as intended.

⁷ Institute for Health Economics and Alberta Health Services, “How Much Should We Spend on Mental Health?” 2008

⁸ Institute for Health Economics, “The Cost of Mental Health and Substance Abuse Services in Canada.” June 2010

Our final point on this matter is that meeting the needs of consumers of mental health and/or addiction services is complex. CMHA, Ontario has been working with others to adapt the chronic disease management research and principles to meeting the needs of those living with mental illness. The need to look at the whole person and their needs is an important lesson for system planning. A recent journal article from SEEI entitled, “Funding Growth and Service Match: More of the Same or Doing Things Better?”⁹ pointed out that, “*Although mental health treatment often involves complex processes of care spanning multiple care providers, and even systems of care, only rarely have evaluations considered the effects of system-level changes on the quality of care provided on client outcomes.*” The need to take a system level approach to funding is further supported in another SEEI study that showed bottlenecks occurred in service continuity and access as “*the new services put increased pressure on existing services that did not receive funding increases.*”¹⁰

Moving Upstream

Both reports recognize the social determinants of health approach and emphasize *upstream* action in the forms of early identification and intervention, stigma reduction and prevention and promotion are essential.

While the recognition is important and welcome the continued pressures on available service capacity have resulted in upstream investments that are very limited and often time-limited and project-based. There is considerable research that shows investments in prevention, promotion and early intervention are effective and result in significant long term savings. The implementation of the strategy should ensure that upstream investments are planned and the impacts are measured and evaluated.

Integration

Integration is a necessary and desirable goal to be pursued. However, lack of integration is not attributable directly to the number of agencies that exist. Achieving integration is complex and multi-faceted. Our own experience in Ontario with hospital

⁹ Stuart, H., Krupa, T., Koller, M., “*Funding Growth and Service Match: More of the Same, or Doing Things Better?*” Canadian Journal of Community Health Vol. 29 Special Issue Supplement 2010

¹⁰ Dewa, C., Jacobson, N., Durbin, J, Lin, E., Zipursky, R. Goering, P., “*Examining the Effects of Enhanced Funding for Specialized Community Mental Health Programs on Continuity of Care,*” Canadian Journal of Community Health Vol. 29 Special Issue Supplement 2010

restructuring is ample evidence that integration is not achieved by simply requiring agencies to merge or amalgamate services.

Achieving integration begins not at the point of service delivery but at the organization of government's own actions; and must be carefully managed and coordinated through every step of the process from policy development through to service delivery. It requires a coherence of strategy, policy, funding and incentives emanating from the Province and running through to the point of service delivery. Integration should begin with Ontario developing a set of comprehensive and coordinated directions to promote integration. Policies, funding incentives, eligibility criteria and other rules and protocols should be checked for unintended consequences that preclude integration. For example, if the eligibility criteria for children's mental health services are inconsistent with those of the adult system, then continuity of care is impeded.

There is considerable national and international literature on how to achieve successful integration in health care. Experience shows success is a function of strategy, leadership, information systems, policy, incentives and culture.

While promoting integration is a primary responsibility of the Local Health Integration Networks (LHINs), the Province must play a critical role in the process. Planning for service integration within and beyond the health system needs to be a central focus of the new mental health and addictions strategy.

The complexity of planning and providing coordinated services and supports to address mental health and addictions is why virtually all recent mental health and addiction strategies call for a **whole-of-government** approach. Both reports rightly call for system building across two dimensions – across the lifespan and across government. These are critical success factors for successful integration.

Leadership

Both the Select Committee and MAG reports strongly address the need for leadership if progress is to be achieved. Both reports emphasize the need for the government to develop a strategy for mental health and addictions with the MOHLTC taking the lead in provincial accountability for its implementation. While assigning the leadership role for action to the MOHLTC, each report recognizes that no single ministry 'owns' mental health and addictions; and that a whole of government approach is essential.

The Select Committee recommendation – its priority recommendation – is for the establishment of Mental Health and Addictions Ontario (MHAO). This new organization would report to the MOHLTC and ensure that, *“a single body is responsible for designing, managing, and coordinating the mental health and addictions system, and*

those programs and services are delivered consistently and comprehensively across Ontario..."

The MAG report recommends the establishment of a new Assistant Deputy Minister (ADM) position within the MOHLTC dedicated to supporting the new 10-year strategy. In addition, the MAG calls for the establishment of a Mental Health and Addictions Council. The provincial body would be *"made up of leaders from the LHINs, community mental health and addictions services, hospitals, physicians (primary care and psychiatry), municipalities, school boards, justice and children and youth services."* Reporting to the MOHLTC, it would share many of the accountabilities with the MHAO.

Some historical perspective is useful when considering these recommendations. In the mid-1980's and early 1990's, the MOHLTC had a dedicated Mental Health Division, led by an Assistant Deputy Minister (ADM), to guide the efforts for reform and investment for mental health and addictions. Ministry efforts were further supported by planning and community engagement undertaken by District Health Councils (DHC) across the Province.

Subsequently, with the establishment of MOHLTC Regional Offices, support responsibilities for mental health and addictions were transferred to the regional offices along with some of the former staff. The dedicated ADM position was eliminated. DHCs continued their work in assisting regional offices in planning and funding for mental health and addiction services. When LHINs were established, the resources of the regional offices were lost along with the DHCs and their staff. It is worth noting, however, that the Provincial priority setting exercise that was part of the formation process of the LHINs resulted in mental health and addictions being at the top of the list for action by the LHINs – just as the policy and planning capacity for action was at its lowest level in 25 years.

Mental health and/or addiction authorities (like those recommended in the reports) have existed in both Canadian and international jurisdictions. New Brunswick and Alberta both had provincial bodies that have been disbanded recently. British Columbia still has such a body, BC Mental Health and Addictions, but its mandate is quite limited.

As with any special purpose body, the overall experience has been mixed in terms of perceived success or failure. Formal evaluation of such models is limited and information that does exist must be considered within the environment and framework of the particular jurisdiction's health system. In considering the right solution for Ontario, a number of factors are important:

1. The selected model must be very clear about the scope and specific authority of the provincial body. Confusion over responsibilities vis a vis other players –

MOHLTC, LHINs and providers - can be highly problematic. As well, the scope of responsibilities must be clear – advisory, decision-making, funder, evaluation and monitoring? Does the body report to the Minister or Ministry? Is the scope limited to service delivery or the full range of relevant social determinants?

2. The role of consumers and families must be explicitly expressed. The selected model should recognize consumer experience and needs and integrate their voice into the decision-making process.
3. Is the Provincial body an advocate for those in need or is its mandate confined to responsibilities assigned by the government?
4. How does the Provincial body work with and build on the historical knowledge, expertise and networks of existing provincial mental health and addiction organizations?

There are many such matters that must be explicitly addressed in the strategy.

Is There a Best Model?

The desirability and authority of a provincial body in Ontario has been the subject of considerable discussion for many years. No one ‘right’ model has been put forth and agreed upon. But what is generally accepted is the model selected must fit the current state and the structure of the whole system.

In 2005, CMHA, Ontario in collaboration with the Centre for Addiction and Mental Health and the Ontario Federation of Community Mental Health and Addictions Programs recommended the creation of a provincial network/authority to lead system reform. The report, entitled “A Strong Provincial Focus” stated:

“We are recommending the creation of a formal network or authority, of addictions and mental health clients, service providers, researchers, and planners across the community/hospital continuum to fulfill cross regional functions and develop tools for our sector to participate in LHINs and other health care reform initiatives. Drawn from the sectors it will affect/influence, this network authority would have a mandate formally accepted by government, with staff and resources to carry out a leadership role for the mental health and addictions sector in the health system.”

This model, which shares a vision similar to both the proposed Council and the MHAO, was not implemented.

While provincial, arms-length organizations such as the models above have merit and should be seriously considered, other approaches do exist; for example:

- re-creation of a Mental Health and Addictions Division under a dedicated ADM within the MOHLTC;
- development of a new Ministry of Mental Health and Addiction;
- development of a Mental Health and Addictions Secretariat within Cabinet Office (as per the Climate Change Secretariat);
- development of a Provincial Mental Health and Addictions Network with similar powers and mandate to the LHINs;
- development of a Premier’s Council on Mental Health and Addictions (Council composed of Ministers whose portfolios impact on mental health and addictions, non-profit and private sector leaders).

What is clear is the current lack of focus and decentralized leadership is not, and likely cannot, effectively implement and monitor the strategies and recommendations of either report. If the new 10-year strategy builds on the findings of these reports then it will need some type of overarching mechanism to be successful.

Two final points of caution on leadership:

- As a consequence of the process by which the LHINs were implemented there was a devastating loss of expertise that existed within the MOHLTC and the DHCs. Any provincial model that is pursued should take considerable care to preserve and utilize the expertise that still exists within the current provincial organizations.
- Structure and organization cannot solve problems of inadequate capacity. The best predictor of success for client outcomes and system effectiveness may well be most influenced by sufficient investment for capacity building.

CMHA, Ontario’s Advice on Leadership

It is CMHA, Ontario’s recommendation that a two-pronged strategy is essential. Internally the Government must enhance its capacity to develop the policy and program frameworks that are required for strategy implementation. This includes whole of government approaches and practices. Secondly, the government must develop external (arms length) mechanisms for overseeing and reporting on the progress in strategy implementation.

While the strategy sets out the vision and direction, the implementation strategy will require significant work over the next 24-36 months. A key success factor will be

building a system level plan that addresses needs across the lifespan and across the myriad of government programs. In the first instance the government should consider utilizing the lessons learned from the former Premier's Council on Health Strategy. This Council brought together the Ministers responsible for service delivery with public and private sector leaders to provide a leadership focus that served as the bridge from vision to action. If such a Council is established for the new strategy, it could be chaired by the Premier, Deputy Premier or Minister of Health and Long-Term Care.

At the same time, the government will need to enhance its internal capacity to carry out the work. This can be achieved through building new capacity or seconding a team to do the work. A senior bureaucratic leader will be needed to ensure accountability and focus.

Once the implementation plan is complete an arms-length body, like those recommended above, could replace the Council.

Conclusions

The impacts of mental illness and addictions touch more Ontarians than any other health issue. The economic impacts alone provide an unquestionable need for action. We know what needs to be done. A well-conceived and implemented 10-year strategy can make a real difference in the lives of hundreds of thousands of Ontarians.

Success will require a partnership of government, public and private sector, consumers, families and communities. It is complex but feasible. The Legislature of Ontario across all parties has embraced the need for change. The Minister of Health and Long-Term Care on behalf of the Government of Ontario has taken the first steps to a new era. The much anticipated 10-year mental health and addictions strategy can begin a process of positive change.

The reports from the Minister's Advisory Group and the Select Committee lay a foundation. In this report we have tried to add a positive voice to our partners to further the development of the plan. The time for bold and decisive action has come. CMHA, Ontario looks forward to being a part of the new era.

Bibliography

Canadian Mental Health Association, Ontario, "The Windows of Opportunity for Mental Health Reform in Ontario," March 2010

Dewa, C., Jacobson, N., Durbin, J, Lin, E., Zipursky, R. Goering, P., *"Examining the Effects of Enhanced Funding for Specialized Community Mental Health Programs on Continuity of Care."* Canadian Journal of Community Health Vol. 29 Special Issue Supplement 2010

Institute for Health Economics and Alberta Health Services, "How Much Should We Spend on Mental Health?" 2008

Institute for Health Economics, "The Cost of Mental Health and Substance Abuse Services in Canada." June 2010

Jacobs, P., Yim, R., Ohinmaa, A., Eng, K., Dewa, C., Bland, R., Block, R., Slomp, M., The Canadian Journal of Psychiatry, Vol. 53. No 5, "Expenditures on Mental Health and Addictions for Canadian Provinces in 2003/04," May 2008

Ontario Federation of Community Mental Health and Addiction Programs. Consumer Survivor Initiatives in Ontario: Building for an Equitable Future. June 2009

Report to the Minister of Health and Long Term Care From the Minister's Advisory Group on the 10-Year Mental Health and Addictions Strategy, "Respect, Recovery, Resilience," December 2010.

Select Committee on Mental Health and Addictions Final Report, "Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians," 2nd Session, 39th Parliament, 2010.

Stuart, H., Krupa, T., Koller, M., *"Funding Growth and Service Match: More of the Same, or Doing Things Better?"* Canadian Journal of Community Health Vol. 29 Special Issue Supplement 2010