Institute for Advancements in Mental Health

REPORT CARD ON

Complex Mental Health

Ontario's mental health system does not consistently meet the needs of people living with complex and persistent mental illness, resulting in repeated gaps across care, continuity, and recovery support.

EXECUTIVE SUMMARY

This report card finds that Ontario's mental health system consistently underperforms for people living with complex and persistent mental illness. **Produced by the Institute for Advancements in Mental Health (IAM)**, it examines system performance across six domains and finds that in four, outcomes fall well short of what people and families need to achieve stability and recovery.

The system was built to treat crises. It was not built to support recovery. For people living with schizophrenia, bipolar disorder, psychosis, and related conditions, that distinction is the difference between a life interrupted and a life rebuilt.

Domain	In brief
Long-term recovery support	System built for crisis, not continuity
Navigation & coordination	Siloed systems, families left to cope alone
Affordability	Therapy out of pocket; medication gaps
Access to care	Long waits, geography, no family doctor
Stigma & emergency response	Dismissal in ERs; stigma blocks help-seeking
Community-based innovation	Promising models exist but are underfunded

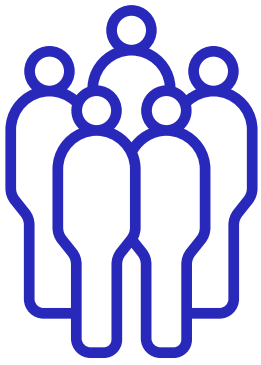
The Bottom Line:

Canada allocates only 7% of its healthcare budget to mental health — among the lowest of peer nations, which invest 10–13%. Ontario has strong programs that show what good can look like, and the government's vision for a provincial central access process could help address persistent challenges around access, wait times, and system navigation. What is needed now is the political will to define mental health outcomes more clearly — and the sustained funding to scale what works.

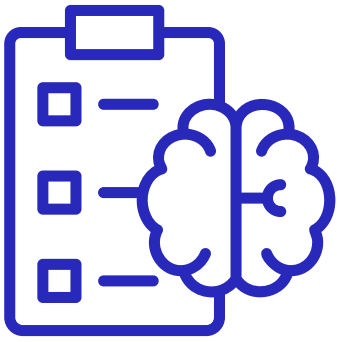
WHAT THIS REPORT RECOMMENDS

Government:
Fund long-term, community-based mental health supports as an essential service, not an afterthought.

Funders:
Shift from output-based to outcome-based funding tied to recovery, housing stability, and reduced hospitalization.



The Public:
Challenge stigma — in emergency rooms, workplaces, and communities — and advocate for parity between mental and physical health.



Mental Health Organizations:
Shift from output-based to outcome-based funding tied to recovery, housing stability, and reduced hospitalization.

Section 1:
The State of Complex Mental Health in Ontario

WHO ARE WE TALKING ABOUT?

When we say "complex mental health," we mean the people the system was not built for.

People living with schizophrenia, schizoaffective disorder, bipolar disorder, psychosis, and severe and persistent mental illness (SPMI) who require not just clinical treatment but long-term, wraparound support to stabilize, recover, and rebuild their lives.

These are not rare conditions. They are some of the most disabling in the world — and they are profoundly misunderstood.

KEY FACTS

- Schizophrenia affects approximately **1 in 100 people** over their lifetime.
- Bipolar disorder affects roughly **2–3% of the Canadian population.**
- Up to **97% of people with schizophrenia** experience some level of impaired insight (anosognosia) — a neurological symptom, not stubbornness.
- **Among people with bipolar disorder, 40–50% have impaired insight** — lowest during manic or psychotic episodes.
- After three years, **45% of first-episode psychosis patients still lack insight into their illness, and 36% into their need for treatment.**

Anosognosia is not a choice. It is a neurological feature of the illness. The system must be designed around this reality, not around the assumption that patients who don't engage simply don't want help.

Where people with complex needs live

Roughly **20–40% of people living with complex mental illness experience chronic homelessness** at some point, with higher rates in urban, under-resourced, and fragmented care systems.

Complex mental illness is highly over-represented among the chronically homeless. In fact:

- ~ 30% of chronically homeless adults have a serious mental illness (SMI) such as schizophrenia, bipolar disorder, or major psychotic depression
- ~ 70–75% have either SMI, substance use disorder, or both

Supportive and supported housing — the primary community residence for people with complex mental illness, ranging from staffed residential settings to independent living with case management support.

HART Hubs — as of 2025, Ontario has established 28 Homelessness and Addiction Recovery Treatment Hubs in cities including Toronto, Ottawa, Hamilton, and Kitchener, serving as integrated access points.

Custodial and residential care — Homes for Special Care and private group homes providing room, board, and medication supervision.

Family homes — a substantial proportion of adults with complex mental illness live with aging parents or family members acting as primary caregivers, often without training or compensation.

Psychiatric units and ALC beds — many individuals remain hospitalized as Alternate Level of Care patients because they no longer require acute care but have no supported home to transition to

For many people, ALC reflects extended hospital stays rather than a short transition, and discharge without sustained community support often leads back to crisis.

Lived Experience Story

Marcus, 24

Marcus was referred for a first-episode psychosis assessment at 22. He waited fourteen months. In that time, he was hospitalized twice, lost his part-time job, and withdrew from college. By the time he accessed community support, the early intervention window had passed. His family had spent those months navigating a system that gave them no roadmap.

Section 2:
System Gaps and Barriers

The six domains below represent the most critical pressure points in the system as experienced by people living with complex mental illness, their families, and the organizations that serve them.

Domain 1: Long-Term Recovery Support

Domain 2: Navigation and Coordination

Domain 3: Affordability

Domain 4: Access to Care

Domain 5: Stigma and Emergency Response

Domain 6: Community Based Innovation

Domain 1: Long-Term Recovery Support

Long-term recovery support refers to the funded, sustained ability for a person to remain connected to care and community life over years, not weeks, including during relapse and re-entry. It includes the supports that stabilize housing, income, relationships, education or employment, and physical and mental health.

For people with complex mental illness, stability is not achieved through time-limited care. It depends on continuity, flexibility, and the ability to stay connected even when symptoms fluctuate or circumstances change.

What We Mean by Long-Term Recovery Support

Ontario's mental health system is most reliably resourced to respond during moments of crisis. It is far less consistent at sustaining support once the crisis has passed.

People living with complex mental illness are frequently discharged from hospital or time-limited services without a confirmed community follow-up, clear coordination across life needs, or a named point of accountability for continuity. These gaps are not the result of individual or provider failure. They reflect a system that has not built long-term recovery infrastructure into its core design.

As a result, many people cycle repeatedly through emergency departments and inpatient units — not because long-term stability is unattainable, but because the supports required to maintain it are not consistently available.

What Long-Term Recovery Support Requires in Practice

Continuity after discharge

The period immediately following hospital discharge is one of the highest-risk moments in a person's journey. Yet too many people leave hospital without a confirmed community follow-up, clear care coordination, or a named person responsible for continuity. Gaps at this stage contribute to relapse, readmission, and loss of trust.

Beyond Short Term Care

Many services are designed around short episodes of care, with discharge tied to temporary stability. For people with complex mental illness, setbacks are common and expected — but re-entry is often slow or blocked. Support should not be withdrawn at the first sign of stability if stability cannot be sustained without it.

Psychosocial Rehabilitation

Long-term stability depends on more than symptom management. Supports for education, employment, daily living skills, income stability, and social connection are essential — yet consistently underfunded. Without this middle layer of recovery infrastructure, people may remain clinically stable while continuing to experience exclusion, poverty, and disconnection.

Housing-Linked Recovery Supports

Stable housing with appropriate supports is foundational. Long waitlists, limited supportive housing supply, and weak coordination between housing and health services leave many people stuck in hospital longer than needed, or cycling between unstable settings.

Family and Caregiver Sustainment

Families frequently become default coordinators, advocates, and crisis planners — often without training, respite, or ongoing support. Caregiver burnout directly undermines long-term stability, yet caregiver sustainment remains under-recognized in system design.

A Stable, Relationship-Based Workforce

Continuity depends on consistent relationships. High turnover, short-term contracts, and fragmented roles undermine trust and long-term engagement. A skilled workforce with the mandate and capacity to support people over time is a core component of effective recovery infrastructure.

Situating This Within System Change

Recent investments in early intervention, integration, and centralized access are important. However, **they do not by themselves address the long-term continuity people need after crisis or discharge.**

Recovery infrastructure must be sustained over years, not tied only to intake, brief stabilization milestones, or time-limited eligibility.

Long-term gaps are often experienced unevenly, with Indigenous, racialized, rural, and newcomer communities facing additional barriers to continuity and culturally responsive support.

Evidence of What Works

It is important to distinguish between approaches that are often grouped together but operate at different levels of the mental health system.

Assertive Community Treatment (ACT) demonstrates how structured, multidisciplinary program models can support people with high needs when sustained over time.

Open Dialogue reflects a care philosophy emphasizing relational continuity, rapid response, and shared decision-making.

Community-embedded system approaches, drawn from international experience, illustrate how organizing care around community life rather than institutions improves continuity and long-term stability.

These examples operate at different levels — program model, care philosophy, and system design — **but share a common principle: outcomes improve when time horizons align with need, continuity is built into the system, and coordinated investment is sustained over time.**

Long-term recovery support is not an add-on to clinical care. It is a preventive investment that reduces avoidable crises, supports autonomy, and improves quality of life.

At minimum, effective recovery infrastructure requires:

Support without arbitrary time limits, where re-entry is expected and setbacks do not result in loss of care

Housing and supports that move together, with real flow between systems rather than parallel waitlists

A named, accountable relationship — a person or team responsible for continuity across transitions

Outcome measures that reflect continuity, stability, and quality of life over time, not just service throughout

Domain 2: Navigation and Coordination

Mental health, addictions, housing, and social supports remain deeply siloed. People must navigate multiple systems that rarely communicate with each other.

Ontario Health, the Ontario Hospital Association, and CAMH all identify hospital-to-community transitions as a major system failure, particularly for people with mental health and addiction challenges.

The period immediately after psychiatric discharge is associated with:

- Elevated suicide risk
- High relapse and readmission rates
- Loss of follow-up care, especially when community services are not pre-connected before discharge

Health Quality Ontario found discharge processes frequently rely on informal advocacy by families and are inconsistent in coordination, medication continuity, and home/community care initiation

Families become default case managers — coordinating appointments, managing crises, and advocating across systems — without training, compensation, or respite.

Ontario Health has made "coordinated access" a formal priority within mental health and addictions system transformation:

Ontario Health regions are developing and piloting coordinated access / centralized intake models to route people to "the right service at the right time" rather than leaving navigation to individuals and families.

For this reason, the effectiveness of every other domain depends on continuity and stability over time. Without them, improvements in access or coordination cannot translate into lasting quality of life.

The IAM Difference

IAM provides healthcare navigation services for individuals and families, connecting people to the right supports at the right time and ensuring continuity across clinical, social, and recovery-oriented care.

Domain 3: Affordability

The majority of psychotherapy and counselling is not covered by OHIP. In Ontario, OHIP generally covers only physician-delivered mental health care, such as care provided by psychiatrists or some family physicians. Psychotherapy, counselling, and talk therapy delivered by psychologists, psychotherapists, or social workers in private practice are typically not OHIP-covered.

As a result, access to mental health treatment often depends on private insurance or personal income — a profound equity gap.

Newer, safer psychiatric medications can be expensive. **Access depends on whether public drug programs include them, which varies.**

Poverty is both a cause and a consequence of mental illness. The Ontario Disability Support Program (ODSP) provides income support widely acknowledged as inadequate for the cost of living.

Domain 4: Access to Care

Wait times for psychiatric assessments, specialized therapy, and community mental health supports routinely stretch from months to over a year. In Ontario, psychiatry wait times commonly exceed 4–12 months, especially for non-urgent outpatient and specialized services, with documented backlogs of 9–12 months in hospital clinics prior to intervention. Unlike surgical care, Ontario does not mandate public reporting of psychiatric wait times, which masks the full scope of delay and reinforces inequity.

Many people with schizophrenia, bipolar disorder, or psychosis do not have a family doctor — the primary gateway to referrals.

As of 2023–2024, 1.8–2.2 million Ontarians lacked a regular family doctor, with projections exceeding 3 million by 2025 due to retirements and workforce attrition. People living with schizophrenia experience disrupted, inconsistent, or absent primary care at much higher rates than the general population, even when nominally "attached," leading to missed monitoring and referrals. Because primary care is the gateway to psychiatry, lack of attachment significantly delays diagnosis, referrals, and continuity — a recognized structural failure in Ontario's system.

Urban centres may have comparatively more services; however, **rural and northern Ontario communities face severe shortages of specialized care and psychiatrists.**

Centre for Addiction and Mental Health policy analysis further notes that only a minority of people experiencing first-episode psychosis receive timely Early Psychosis Intervention (EPI), largely due to referral bottlenecks, workforce shortages, and geographic barriers. CAMH policy analysis notes that only a minority of people experiencing first-episode psychosis receive timely EPI, largely due to referral bottlenecks, workforce shortages, and geography.

Mental health care works best when it is continuous, coordinated, and centred on real life — not just symptoms. The system we have built does the opposite.

Domain 5: Stigma & Emergency Response

People with complex mental illness report being dismissed, undertreated, or receiving lower-quality care when they present at emergency departments and general health settings.

Stigma operates as a structural barrier, not just an interpersonal one. It affects housing applications, employment, and willingness to seek help.

Over half of people with mental illness do not seek help due to fear of stigma, prejudice, and discrimination — a figure that has barely moved in a decade.

Emergency departments are not equipped to provide appropriate care for psychiatric crises, yet they remain the primary entry point for many people with complex needs.

Domain 6: Community-Based Innovation

This is the brightest corner of the report card. Ontario has demonstrated, through programs like Assertive Community Treatment (ACT) teams, HART Hubs, and organizations like IAM, that community-based, long-term, person-centred models work. The challenge is not evidence — it is scale and funding.

Assertive Community Treatment (ACT) teams bring multidisciplinary care directly to individuals in their homes and communities. Evidence consistently shows reduced hospitalization, improved housing stability, and better quality of life.

Integrated case management — long-term, intensive coordination across health, social, and legal systems — is among the most effective interventions for people with complex needs.

Peer support programs, digital navigation tools, and caregiver education platforms show strong results but remain funded on a project-by-project basis rather than as core services.

Section 3:
The Human Cost

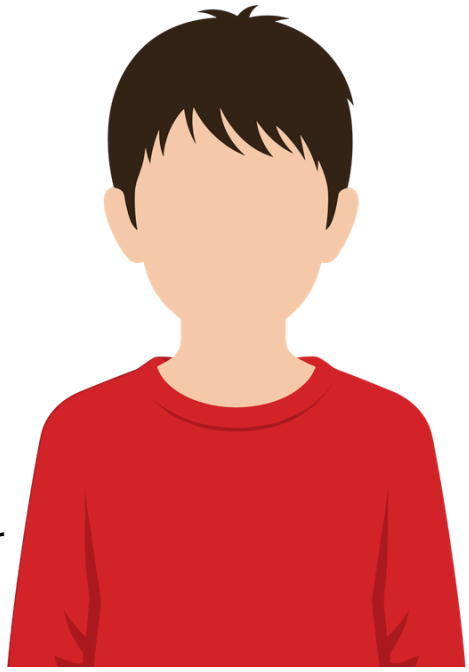
Behind every gap in this report is a person. The following stories are composites drawn from the experiences of individuals and families supported by IAM. They are representative of the patterns documented throughout this report.

Diane, 58 — a caregiver

Diane's son was diagnosed with schizophrenia at 21. For twelve years, she has been his case manager, his advocate, his crisis planner, and his only consistent support. She has attended more hospital discharge meetings than she can count, each time being told that a community service would be in touch. It rarely was. She has missed promotions, depleted her savings, and developed her own anxiety managing a system that treats her as a resource rather than a person in need of support herself.

James, 31 — a person in recovery

James was hospitalized three times in two years before he was connected to a community mental health team that provided consistent, long-term support. With stable housing, a supported return to education, and a counsellor who knew his history, he has been stable for four years. He now volunteers at a peer support program. The difference, he says, was not medication — it was having someone in his corner who did not give up when he relapsed.



These stories describe the ordinary experience of families navigating a system that was not designed for them — and the transformative difference that continuous, community-based support can make when it is available.

Section 4:
Positive Examples of Success

Assertive Community Treatment (ACT)

ACT teams are multidisciplinary, mobile teams that provide intensive, long-term support directly in a person's community for a small, high-acuity population with serious mental illness. Decades of evidence across North America and Europe show that ACT reduces hospitalization, improves housing stability, and supports functional recovery, including employment. Ontario has ACT teams, but capacity is limited and access is inequitable across the province, leaving many people with complex needs unsupported outside of acute care.

Trieste, Italy — a system built for community

The city of Trieste eliminated its psychiatric hospital in 1978 and replaced it with a network of 24-hour community mental health centres. The result: far lower rates of hospitalization, high rates of social inclusion, and a model that has been studied and adapted across the world. It is proof that a different architecture for mental health care is possible.

Finland — Open Dialogue

Open Dialogue is a treatment approach developed in western Finland in the 1980s that prioritizes immediate response to psychiatric crises (within 24 hours), involves the person's social network in all treatment, and achieves significantly better long-term outcomes than standard care for first-episode psychosis — including higher rates of return to work and lower rates of medication dependency.

Ontario — what IAM has demonstrated

IAM has built a model that fills the gaps the formal system leaves open: long-term counselling at no cost, navigation support for individuals and families, caregiver education, supported return to education and employment, and investment in digital tools that extend reach.

The outcomes are the kind the system is supposed to produce — stabilization, recovery, and community integration — achieved through the kind of sustained, relationship-based support the system does not currently fund as a core service.

Section 4:
IAM's Model and Evidence

The Institute for Advancements in Mental Health supports people with complex mental health conditions and those for whom the mental health system was not built — providing long-term, practical, community-based support that helps people stabilize, recover, and rebuild their lives.

What IAM provides

Individual and group counselling at no cost to patients and caregivers

Healthcare system navigation services for families and individuals

Education and training for caregivers to reduce burden and improve outcomes

Supported pathways back to education and employment

Innovation in digital tools, including peer support applications and caregiver platforms

Why IAM's model matters for the sector

The gaps IAM fills are structural.

They exist because the formal system is designed around acute episodes, not sustained recovery.

IAM's approach is designed to support continuity over time, combining early engagement with ongoing navigation, cross-sector coordination, and technology-enabled supports that remain available as needs change.

Together, they constitute a community service model of care that the province needs at scale.

IAM fills the gap

IAM provides the long-term, practical support the system doesn't offer — but that recovery requires. For people with complex mental illness, that difference is everything.

Our Recommendations: Government

Fund recovery

Establish dedicated, sustained provincial funding for long-term community-based mental health supports — not one-time grants, not crisis funding, but core service infrastructure.

Cover therapy

Expand OHIP coverage to include psychotherapy and counselling for people with complex mental illness, eliminating the affordability barrier that limits access to evidence-based treatment.

Scale ACT

Double the number of Assertive Community Treatment teams in Ontario and mandate equitable geographic distribution, including rural and northern communities.

Fund navigation

Invest in system navigation infrastructure — including trained navigators and coordination hubs — so that no one is discharged from hospital without a supported community landing.

Raise the benchmark

Commit to increasing Canada's mental health funding share from 7% to at least 10% of the healthcare budget within five years, in line with peer nations.

Our Recommendations: Funders

Fund outcomes

Shift funding criteria from outputs (number of visits, calls made) to outcomes (housing stability, employment, reduced hospitalizations, self-reported recovery).

Multi-year grants

Provide multi-year funding commitments to community organizations so they can build stable teams and sustain relationships — the foundation of effective care.

Fund caregivers

Recognize and support family caregivers as essential partners in the mental health system by funding caregiver education, respite, and peer support programs.

Back innovation

Invest in digital tools that extend reach and reduce barriers, including peer support platforms and navigation applications tested in community settings.

Our Recommendations: Mental Health Organizations

Share data

Break down siloes by sharing outcome data, referral pathways, and service capacity across organizations so the sector can learn collectively.

Include lived experience

Embed people with lived experience of complex mental illness in program design, quality improvement, and advocacy at every level.

Coordinate, don't compete

Develop shared intake and referral protocols so that the first door a person opens is the right door, not the only door they ever reach.

Our Recommendations: General Public

Learn

Learn what complex mental illness actually is — and what it is not. Anosognosia is not stubbornness. Treatment resistance is not failure. Recovery is not linear.

Be Active

Challenge stigma when you encounter it: in emergency rooms, workplaces, and communities.

Fund

Support organizations like IAM that fill the gaps the formal system leaves open.

Advocate

Talk to your elected representatives about mental health funding. Public pressure moves budgets.

A FINAL WORD

The mental health system in Ontario is not broken because no one cares. **It is underperforming because it was designed for a different problem than the one it faces.**

Acute care models were built to treat episodes. Complex mental illness requires something different: **continuity, community, and the recognition that recovery is a long journey that requires sustained company.**

The people this report is about are not edge cases.
They are the people with the highest need, the most difficult circumstances, and the greatest capacity to recover — if the right supports are in place.

IAM has seen that recovery firsthand. The evidence is not theoretical. The question is whether Ontario will choose to build the system it claims to want.

"The system was built for crisis.
We are building for the rest of a person's life."