EQUALLY WELL MATCH — SUMMARY REPORT

Protecting and Improving the Physical Health of People Living with Mental Health Conditions

Thirty participants from six countries met in a two-day hybrid working session to mobilize evidence, transform care models and advance equity — and to bring the Equally Well movement to Canada.

CONVENED AT
Centre for Addiction and Mental Health, Toronto

DELEGATIONS
Australia · Canada · Ireland · New Zealand · UK · USA

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ABOUT EQUALLY WELL

Equally Well is an international movement dedicated to ensuring that people living with mental health conditions have access to the same quality of physical healthcare as everyone else.

Drawing on research and lived expertise, we advocate for well-resourced, integrated systems that bring physical and mental healthcare together, value lived experience and are accountable for their outcomes.

Our work is grounded in the belief that physical and mental health are fundamental human rights.

ACKNOWLEDGEMENTS

With thanks to **Dale Morris** and **Andrew Kirkwood**, who captured the meeting and drafted this report, and to all match participants who contributed to the event and to the final version of this report.

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INTRODUCTION

"I want tools and I want action."

QUOTE FROM THE MATCH

As one participant in the June 2026 Equally Well match event put it: "Movement-building is tricky." It takes effort to align partners with different expertise, means and reach — and to convert intentions into action. Yet building a movement was exactly the ambition of the group that gathered at Toronto's Centre for Addiction and Mental Health (CAMH) to take part in *Equally Well: Protecting and Improving the Physical Health of People Living with Mental Health Conditions*.

The match event was one of several organized for June 1 and 2 under the umbrella of the Global Leadership Exchange (GLE), which connects leaders in mental health, disability, substance use and addictions to share knowledge, spread innovation and change lives. For the Equally Well match, thirty participants from Australia, Canada, Ireland, New Zealand, the UK and the United States came together in a two-day hybrid working session — clinicians, researchers, policymakers, government representatives, health system administrators, advocates and people with lived experience of mental health issues and the intersections between physical and mental health.

Building on previous Equally Well matches in 2022 and 2024, the group sought to mobilize evidence, informing collective solutions to transform care models and advance equity. While the main focus was on further strengthening Equally Well as an international movement, the match also aimed to identify ways of bringing that movement to Canada specifically.

The two-day agenda traced a deliberate arc from talking and sharing to learning and making commitments. Participants said they wanted to learn, come away with concrete, actionable outcomes and policy tools, and build lasting relationships for ongoing collaboration. Progress was made toward all of those goals. Key themes were distilled into guiding principles and commitments were captured in a summary for sharing at the subsequent GLE World Café in Ottawa, Canada.

Equally Well match, Centre for Addiction and Mental Health, Toronto, June 1–2, 2026.

Small group breakout, Day 1.

WATCH THE VIDEO

Personal perspectives on Equally Well

Global Leadership Exchange · youtube.com

02 MATCH HIGHLIGHTS

The match agenda was built around thematic blocks of presentations and discussions, starting with a session on the importance of embedding lived and living experience in the design and planning of integrated care. That segment was followed by an overview of Equally Well efforts in various jurisdictions; an exploration of collective impact approaches; perspective from the Canadian province of Ontario; and reflections on the development of a scorecard to measure progress.

The final sessions on Day 2 dug into the work of defining a vision, guiding principles, actions and commitments to build further momentum and attract more partners to the Equally Well movement beyond the match.

WHAT WE STAND FOR

The physical health needs of people with mental illnesses are often overlooked. We advocate for a well-resourced, accountable, integrated system that brings physical and mental healthcare together and values lived experience.

GUIDING PRINCIPLES IN BRIEF

1. Equity of access
2. Multi-level action
3. Genuine inclusion
4. Embedding lived experience
5. Evidence-based practice and practice-based evidence
6. Collective impact
7. Data collection and measurement
8. Partnership and collaboration
9. Continuous communication
10. Pursuing near-term actions
11. Incorporation into medical training, education and accreditation standards

SELECT ACTION COMMITMENTS

International call to action · International scorecard · WHO benchmarking · National communities of practice · Equally Well communications guidelines · International Collaborative Learning Network sharing

Figure 1. Highlights of match takeaways.

GET INVOLVED

Equally Well grows through partners who bring their own reach, evidence and lived expertise to the work.

TO JOIN THE MOVEMENT OR GET IN TOUCH

Equally Well International

Act now. Include us.

DAY 1

Power, voice, and the people we keep missing

TOWARD GENUINE INCLUSION

Konstantina (Dina) Poursanidou, a survivor-researcher and service user from the UK, shared her perspective that "lived experience leadership" — a stated goal of Equally Well — can only be realized with genuine inclusion of people with lived experience in policy development, research and clinical practice. She touched on current barriers to genuine inclusion, including:

- **Tokenism** — when people with lived experience are involved in unmeaningful ways as a tick-box for research funding or a rubber-stamp exercise by policymakers
- **Power hierarchies** that keep the people closest to the problem farthest from the rooms where decisions are made
- **Narrative co-optation** of people's stories under the guise of co-production to justify pre-existing interests

Dina noted that while lived experience is not infallible, involving people with that experience results in policies and practices more relevant to the needs and priorities of mental health service users. This in turn promotes greater community buy-in and uptake.

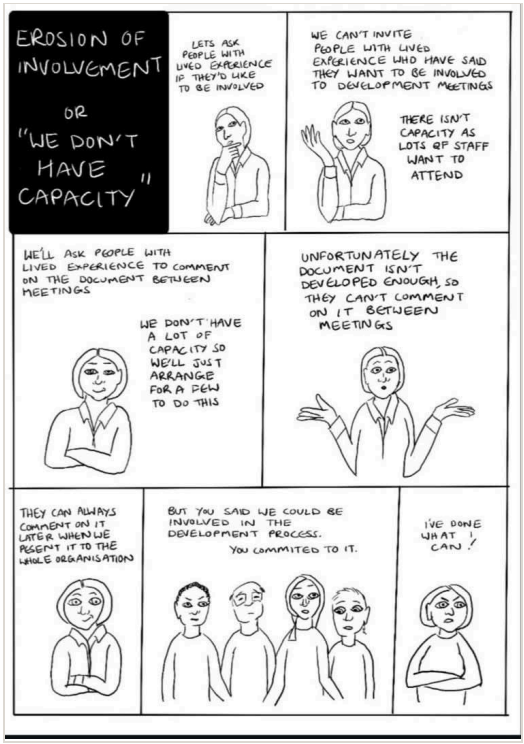

Figure 2. The experience of eroding involvement. Cartoon by Tamsin Walker, from Dina Poursanidou's presentation.

"BAKED INTO THE CAKE"

Rick Ybarra of the U.S. Hogg Foundation anchored his presentation in the philanthropical belief that "health starts at home" — in neighbourhoods and communities. He described how the Hogg Foundation has embedded lived experience in upstream community governance structures to achieve real impact and what he calls "durability" (as opposed to mere sustainability, which tends to be concerned with securing the next round of grants).

At Hogg, people with lived experience are "baked into the cake", not treated as tokenistic "icing and sprinkles". They serve as recovery and peer coordinators in publicly funded mental health and behavioral health services with the ability to bill for peer support; as active co-investigators in community-based research projects; and as majority members with real decision-making power on boards of federally qualified health centres. Requirements for involving people with lived experience can also be built into contractual and funding processes.

Advocacy efforts matter too: amplifying voices through community mobilization, letter-writing campaigns, appeals to legislators and policymakers, and involving key influencers to create "bigger ripples in the pond".

EXPERTISE BY EXPERIENCE

Equally Well UK colleagues Andy Bell and Shizana Arshad spoke about their team's efforts to build experiential leadership into governance and co-production practices. Andy shared a few lessons learned:

- Situating Equally Well UK within the Centre for Mental Health has been important. Being part of a small organization of roughly 25 staff — versus a large service provider — has allowed the team to focus on fundraising, research and knowledge-building.
- Integrating "experts by experience" and clinical groups was a critical step. With more equitable discussion, increased power sharing and intentional effort to bring in more cultural diversity, Equally Well UK has implemented a more authentically "nothing about us without us" approach.

Shizana reflected on what it means to value lived experience, noting the emotional impact when experts by experience retell their stories. She called for organizations to create safe psychological spaces and offer appropriate supports and compensation. Given the risk of tokenism, it is important for people with lived experience to participate fully in roundtable discussions rather than simply share stories — fuller participation leads to better research and understanding.

On collaborating with other physical health organizations such as cancer agencies, Shizana said doing so builds resonance beyond the mental health community. She also said back-office functions are critical to driving action: "Infrastructure is not a luxury."

TOOL

Co-defining the dilemma

TAMARACK INSTITUTE

A tool for identifying stakeholders and confirming who should be part of a co-design initiative. Link »

What the world has learned

THE LAUNCHPAD: NEW ZEALAND

Helen Lockett reflected on the achievements and lessons learned since Equally Well got its start in New Zealand in 2014, suggesting four key requirements for any national Equally Well effort: leadership, stewardship, a backbone team with funding, and the support of subject-matter experts including people with lived experience.

Lessons learned

- A strong consensus statement makes it easy for partners to sign on and support advocacy initiatives without needing to seek internal permissions every time. Looking back, New Zealand's consensus statement might have been even more effective had it included specific commitments to action.
- Lived experience is evidence and answers crucial questions. Equally Well New Zealand established an informal lived experience stewardship group, though funding limitations have made it hard to sustain.
- People's mental health diagnoses often overshadow their physical health needs, depriving them of care they need. This diagnostic overshadowing needs to be eliminated.
- Movements ebb and flow; New Zealand is at the point of needing to reenergize, potentially through partnerships with other national health organizations and advocacy groups. While partnership is critical, partners have their own priorities.

MONEY MATTERS: UK

Andy Bell and Shizana Arshad said Equally Well UK was inspired by New Zealand's example and adapted its collective impact model to suit the UK context, emphasizing coproduction and expertise by experience.

Ed Beveridge of the Royal College of Psychiatrists noted the diversity of policies across the UK. England has done well, he said: 65% or more of individuals in psychiatric care receive physical health checks, targets exist for referrals to general practitioners and secondary care, and the country's healthcare service framework includes severe mental illness as a condition. Programs have been developed in collaboration with marginalized groups to promote services such as cancer screening, and in Wales the Royal College of Psychiatrists has worked with the government on major reports to advance mental health-minded policies.

While acknowledging that public services in the UK are challenged by tight budgets, Ed said integrated care will continue to be a big topic going forward — influencing service design and funding — along with multidisciplinary approaches to preventing physical and mental illnesses and early mortality.

Lessons learned

- Funding is essential — and hard to come by. People's time, expertise and experience should receive compensation, but many organizations lack resources to pay for lived experience and researchers have tight budgets. Equally Well UK maintains a business development team focused on accessing funding.
- A collective impact approach is critical because no single organization can do it all. At the same time, collective impact requires everyone to understand the part they can play — and what they're accountable for.
- Communication is fundamentally important to developing a sense of community.

- Getting partners to sign a charter is easier than drafting the charter itself, which can be intensive and involved. Without specific commitments to action in a charter, partners may not participate actively or invest.

Lessons learned (continued)

- Physical health organizations may be eager to talk about mental health but often show little regard for the physical health of people with severe mental illnesses.

Other points raised in discussion

- Partners are critical but engagement often happens on partners' terms. "Meeting people where they are is fine, but not if they're unwilling to meet you where you are."
- Primary care practices need to adapt to people's needs and not penalize people with severe mental illnesses for missed appointments.
- Disease diagnosis and treatment pathways are generalized and don't consider exceptional circumstances such as mental illnesses. The UK has seen some change in this by integrating psychiatrists into disease pathways.

THE GOLD STANDARD: IRELAND

Representing Ireland's Health Service Executive (HSE), Brian Higgins spoke about the ways his country has built integrated mental and physical healthcare into legislation, policy and practice. He acknowledged it is not easy to weave all the various instruments and policies together.

Lessons learned

- A strategic approach and clear structure pave the way to better outcomes. Ireland has a national mental health strategy administered by a national Mental Health Commission, as well as a national health strategy, Sláintecare, designed to ensure "right time, right place" healthcare access. Each of the country's six regions has a budgeted health centre complemented by local teams and clinics to ensure resources and services are close to the people who need them.
- People with lived experience should have a role in ensuring accountability. Ireland has a Minister of Mental Health with lived experience who sits in Cabinet. A National Implementation and Monitoring Committee of people with lived experience holds the government to account, and people with lived experience sit on all internal committees of Ireland's health services implementation group. The National Office for Mental Health and Recovery is led by a person with lived experience and matches people to policy advisory roles based on their experiences.

Lessons learned (continued)

- Legislation is powerful but takes time. Ireland has a newly minted Mental Health Act and an Assisted Decision-making (Capacity) Act that brings a service user focus to matters such as involuntary admissions. The latter Act took eight years to come into force after being signed into law.
- Programs reach people. Ireland is "fighting hard to get people on the preventative arm — the tests they need, access to GPs." One tool is a chronic disease management program for people with mental health challenges and chronic diseases. Brian said securing budgets for such programs requires active advocacy to the minister responsible.

GOVERNANCE DRIVES DELIVERY: USA

Debra Pinals of the National Association of State Mental Health Program Directors (NASMHPD) described the interest in and work being done on integrated physical and mental healthcare in the U.S., explaining how the structure of the country's health system influences the ways work is funded and implemented.

Lessons learned

- States depend on federal funding. The U.S. federal government issues grants and directs the Centers for Medicare and Medicaid Services where to focus. States then follow that federal lead while at the same time seeking to realize state policies.
- Governance structures have a direct impact on service delivery. In some cases, primary care providers are building collaborative relationships with mental health specialists who can provide and bill for "curbside care"; in others, community mental health organizations are bringing in primary care services to provide integrated behavioural mental healthcare.

- Innovative models are helping reveal what works: **Health Homes**, which provide holistic care for targeted populations such as people recently released from prison or in high-need geographic areas; and **Certified Community Behavioral Health Clinics** (CCBHCs), local certified clinics providing walk-in screenings, assessments and access to integrated mental and physical healthcare. CCBHCs originated at the state level and have gained traction federally, funded on a population basis rather than pay per use. In some states they have expanded to include addiction, developmental and geriatric mental health specialties, with free expert advice available to primary care providers.

Lessons learned (continued)

- Data and knowledge-sharing help drive change. Data on diabetes management, hypertension, depression screening and other focal issues is being gathered to build the evidence base for integrated services.

Other points raised in discussion

- Primary care providers can lose fees when other organizations offer integrated healthcare services. Collaborative care codes are being used in some U.S. jurisdictions to remedy this. Funding the person rather than the service or the provider is another option, and could make services more people-centered.
- Regardless of the cost of upstream, preventative services, police and emergency room staffing cost governments more.

"EVIDENCE WITH A STORY": AUSTRALIA

Russell Roberts closed out the session with a recap of the Australian Equally Well experience, which began in 2016 and is funded by the federal government to implement the commitments of the country's consensus statement. He said one reconsideration looking back would be to spend more time on communications and potentially to pursue celebrity champions to raise profile.

Lessons learned

- Measurement increases efficacy. In August 2023, the state of South Australia was having poor results with Equally Well. National movement members offered help implementing mandatory key performance indicators and, as of November 2025, that state was a world leader in live reporting, cancer screenings and vaccinations.
- Stories bring evidence to life. Equally Well is now part of Australia's cancer plan. As part of outreach with a national cancer care foundation, one individual offered to tell her personal story of having a cancer diagnosis overshadowed by ideas about her medication and mental health issues. That combination of evidence with a story helped nurses understand the risk of diagnostic overshadowing and fostered better collaboration among providers.
- "Pockets of excellence" aren't always visible. A nurse practitioner unknown to the movement attended an Equally Well Australia conference saying she and her team were following its principles. Russell said there could be others like her, and that allies may not always be identified.

Who needs to act, and where

Day 1 closed with a presentation and group discussion about models for collective impact, a disciplined form of multi-sector collaboration and a framework for policy and programmatic change.

The Tamarack Institute's Sylvia Cheuy walked the group through a collective impact framework rooted in the notion that "change moves at the pace of trust". She overviewed the conditions needed for collective impact: a common agenda or shared vision, shared measurement of meaningful indicators, mutually reinforcing activities (orchestration versus duplicated effort), continuous communication and backbone infrastructure.

Sylvia cited a six-year poverty reduction initiative in Montréal as one example of collectively addressing a complex problem no single organization could tackle on its own. Neighbourhood roundtables became the anchor element in an effort involving the municipal government, Montreal public health, Centraide, nine foundations and others, all of whom contributed resources as they worked to target five areas of poverty reduction.

Asked about challenges building trust at the community level, Sylvia emphasized taking time to find out what is already happening in a community that can be strengthened or aligned with other efforts. She also suggested bringing in different sectors and perspectives and recognizing the multiple system entry points where change can be made. Mindset shifts are needed to appreciate and adapt to complexity, reimagine who leads, embrace community innovation, and think about both programs and systems.

TOOL

Brainstorming Critical Shifts

TAMARACK INSTITUTE

A brainstorming tool used by the Tamarack Institute, shared by Sylvia Cheuy. Link »

The session concluded with small group breakouts in which participants explored two questions: what, in the current state, is not working? And what is the ideal future state? The full set of inputs is captured in Figure 3, with the following emerging as top priorities:

01 Including lived experience as integral and equal

02 Changing funding models to support integrated healthcare services

03 Implementing true cross-sectoral collaboration

04 Improving monitoring and support for physical health in mental health services

05 Recognizing people with mental health conditions as a priority health group

06 Actively prioritizing people with mental illnesses for cancer care services

07 Breaking down data and information silos

08 Resolving trust issues between the system and patients

09 Ensuring that people with mental health conditions enjoy the same life expectancy as those without

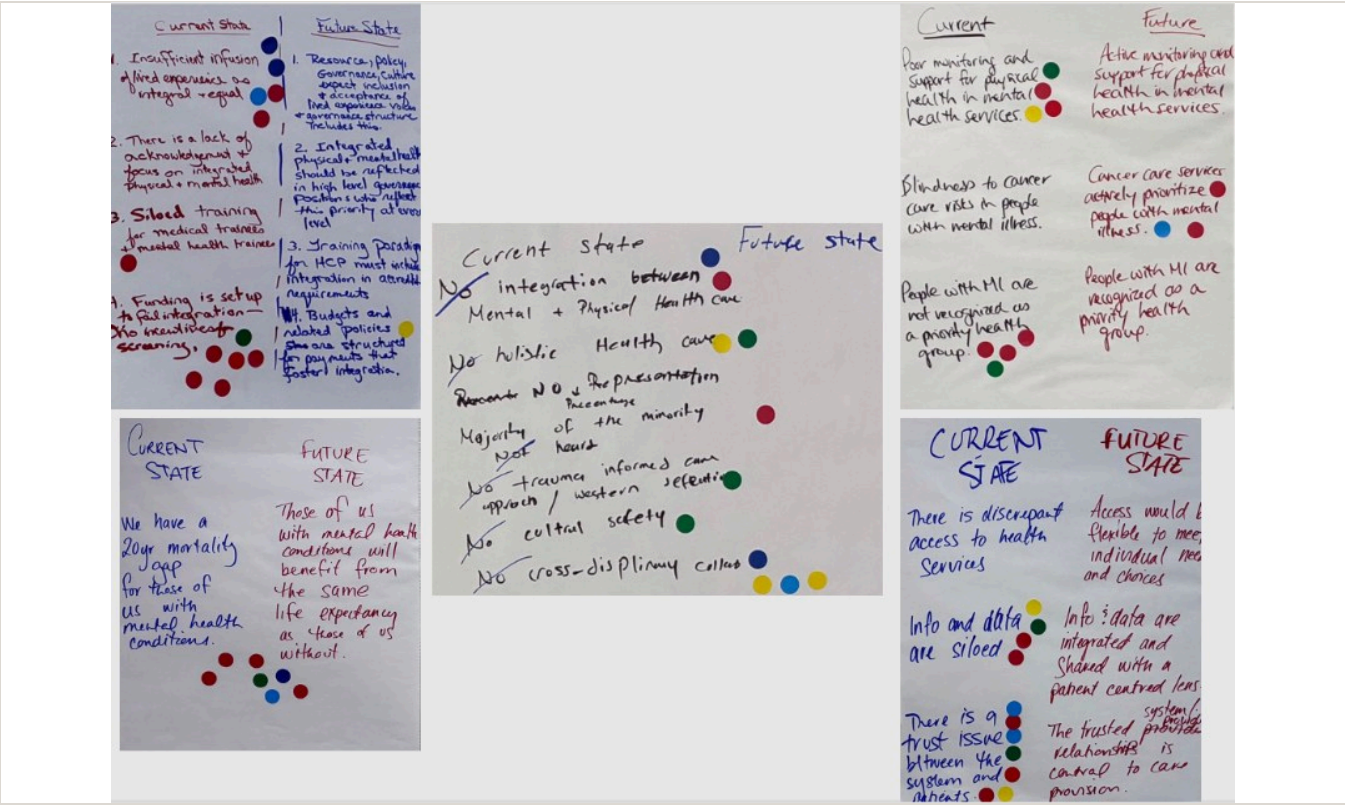

Figure 3. Flipchart reflections on the current and desired future state, with priorities indicated by stickers.

Key takeaways — Day 1

A summary from the day's presentations and discussions

01 Equally Well must be underpinned by equity, diversity, inclusion and social justice. Physical and mental health are basic human rights, and better physical health equals better mental health.

02 Equal wellness requires collaborative multi-level action — policy-, system- and program-level change effected through partnerships.

03 Lived experience leadership demands genuine inclusion and active, consequential roles for people with lived experience. When direct experiences are reflected in policy and practice, buy-in is stronger.

04 Healthcare as a sector could learn from commercial industries, where organizations succeed and attract investment based on how well they understand the needs and wants of their customers.

05 Lived experience is not sacred or infallible, but people have the right to talk about their experiences — and need to be psychologically safe and supported to share their stories.

06 Diagnostic overshadowing has profound impacts and must be addressed. People's mental health conditions cannot be barriers to physical healthcare.

07 Funding is critical for an effective movement.

08 Collective impact is essential but requires clarity about accountabilities.

09 Data and analysis need to be better applied to inform policy. Measurement increases efficacy.

10 Project management and strategic management expertise could help give integrated healthcare projects momentum.

"Change moves at the pace of trust."

QUOTE FROM THE MATCH

DAY 2

The view from Ontario

CREATING A MENTAL HEALTH SYSTEM

Dr Paul Kurdyak of the Mental Health and Addictions Centre of Excellence asserted that Ontario does not have a mental health system today, just "a bunch of funded things." The Centre of Excellence is developing the infrastructure to create a system, in partnership with recognized leaders in cancer, cardiac, stroke, dialysis and other areas of care.

What the province does have is an accountability gap. Even when quality is measured, organizations lack the levers to enact change — and not all people enjoy the same health outcomes; little if any cancer care is delivered to people in shelters or encampments. "It is very easy to dismiss people who are incapable of advocating for themselves."

Paul concluded by making a case for data gathering and measurement. He and his team are engaged in that work today, shining light on areas of the system not visible before. While data projects often don't resonate with politicians because they have long timelines, once metrics start coming in they have real impact. "Now we have a dashboard and they're getting excited."

A FOCUS CASE: SCHIZOPHRENIA IN ONTARIO

30%
less likely to receive the full standard of primary care

50%
more likely to die after a first heart attack

50%
less likely to receive cardiovascular catheterization

All signs of diagnostic overshadowing. Disparities in stroke care are smaller, because stroke care is highly standardized and regionalized.

Other points raised in discussion

- Mental health advocates and system navigators often focus only on mental health issues, but physical healthcare also needs advocating for.
- Screening works for people who can receive a letter in the mail and have a family doctor: the system isn't designed to serve people equally and equitably.
- There may be ways for hospitals to be more "opportunistic" — providing screening services when someone is in their care and sharing results with primary care.

GET ON THE BUS

Dr Tania Tajirian of CAMH framed her presentation by observing that people with severe mental illnesses are up to 50% less likely to receive mammograms, 20% less likely to receive cervical cancer screening, and 10% less likely to receive colorectal cancer screening than people in the general population. Siloed services, diagnostic overshadowing and trauma histories all contribute to this. Tania and her team codesigned a screening program with people with lived experience for inpatients at CAMH, incorporating cancer-specific trauma-informed workflows and electronic health record prompts.

The team brought FIT and self-swab kits onto the inpatient unit for colorectal and cervical screening. While screening rates dropped off after implementation, over time uptake has grown and more people are keeping up to date with screening. The drop-offs may have had to do with trauma, fear, procedural anxiety, limited understanding of screening, and inconsistent staff follow-through due to competing demands.

For breast cancer screening, the team partnered with Women's College Hospital and coordinated offsite "blitzes". The number of screenings completed remained fairly stable even after a policy change increased the number of eligible individuals. On the day of the blitz, three out of four people changed their minds, leading Tania to recognize the need to meet people where they are, when they are ready.

Given that requirement for flexibility, Tania shared her vision of a screening bus that would take services to people in the community and to other mental health hospitals in the province.

> "[When you say] 'here's the evidence', then the dominoes start to fall."
>
> QUOTE FROM THE MATCH

DOING A BETTER JOB

Tania's CAMH colleague, Dr Mahavir Agarwal, spoke about metabolic health and his work helping people on antipsychotics and other medications manage weight gain — a top reason why many young people discontinue treatment. He acknowledged that psychiatrists too often "farm out" responsibility for managing side effects to other providers such as general practitioners who are already overburdened.

Psychiatrists could easily prescribe medications to help patients manage weight gain, and these don't need to be radical or novel: metformin, in clinical use for nearly 70 years and commonly used to treat diabetes, can prevent weight gain induced by clozapine and other antipsychotics. For the best results it needs to be started concurrently with clozapine; if started later, its efficacy declines significantly.

Given the simplicity of the solution, Mahavir called it almost irresponsible not to prescribe metformin, especially because people on it are more likely to stay on clozapine. "There are so many benefits to doing a better job." However, this requires a professional conceptual shift for many psychiatrists. Mahavir said he embeds the idea whenever he works with residents, so the next generation of practitioners will think in these terms.

PAPER

Metformin for the Prevention of Antipsychotic-Induced Weight Gain: Guideline Development and Consensus Validation

SCHIZOPHRENIA BULLETIN

Referred to by Mahavir Agarwal; among the journal's most-read papers. Link »

Other points raised in discussion

- Mitigating medication side effects when possible is a human rights issue and should be embedded in mental health legislation, strategies and practitioner training, including for pharmacists.
- Individuals prescribed antipsychotics could enjoy better health and quality of life if weight gain, pain and other side effects were actively managed — it is painful to learn after the fact that something could have been done.
- Prescribing metformin to complement antipsychotics is in guidelines in Canada, New Zealand and Australia and could be monitored by the World Health Organization, but making it a protocol would carry more weight.
- Ontario Shores has closed its metabolic centre; there was interest in partnering with CAMH and Waypoint on metabolic needs.

Keeping score

Russell Roberts explained that scoring needs to happen at the national level within a country's "authorizing" policy-planning environment, because data collection and measurement are public health policy issues. While cancer, respiratory illness, cardiovascular disease, diabetes and vaccine-preventable illnesses are specialty areas, they require common, high-level guidelines that inform regulations, policies and standard operating procedures.

Helen Lockett illustrated the impact of this approach with details of how data-gathering and national conversations in New Zealand have led to increased uptake of vaccines. She celebrated the successes of various countries addressing other health challenges — New Zealand and opioids, cancer in Australia, mental health in Ireland, and general health policy in Scotland.

Christopher Canning of the Waypoint Centre for Mental Health Care walked through a Canada policy scorecard he developed in 2026 with Konstantina (Dina) Poursanidou and Laura Justine Chouinard. The scorecard measures 83 federal, provincial and territorial health policy documents — mental health strategies, physical health frameworks and chronic disease plans from all jurisdictions — on a scale of 0–15, according to how well they address the health needs that cross the divide.

41%	**3%**
of **physical health** documents score good or excellent on mental health integration	of **mental health** documents score good or excellent on physical health integration

Other findings

- Jurisdictional differences exist across Canada, with provinces such as Saskatchewan, Nova Scotia and Prince Edward Island scoring high on integration of mental health in physical health documents, and Ontario and Quebec showing more balanced cross-discussion.
- Vaccination equity, medication management and monitoring of physical side effects of psychiatric medications are almost entirely absent from all documents.
- With a few exceptions, the documents are written entirely from the perspectives of policy planners and system designers. People with lived experience of mental illness, physical comorbidity or fragmented care are not present as co-developers.

Russell proposed striking a working group and refining the international scorecard to present data from various countries measuring physical and mental health integration. This would be shared with other Global Leadership Exchange members — including non-Western countries — and the World Health Organization to strengthen the Equally Well movement internationally. Attendees including Alison Freeland from the Canadian Psychiatric Association agreed to take part. Russell also secured verbal agreement from Paul Kurdyak, Mahavir Agarwal and Sanjeev Sockalingam to co-author a paper on the scorecard.

Key takeaways — Day 2

A summary from the morning discussions

01 Physical healthcare organizations do well at reaching the “common denominator” of people but aren’t structured to care for people with mental health conditions.

02 Data-gathering and analysis are essential to reveal where people aren’t being served so gaps can be addressed.

03 It is critical to understand why people with mental health conditions may not seek out or go through with screening. Often the reasons have to do with fear and trauma.

04 Physical side effects such as weight gain can affect quality of life and deter people from staying on medications, yet simple, proven solutions like prescribing metformin exist.

05 Measurement through a standardized scorecard could be a powerful way to baseline the Equally Well movement, onboard new members and drive outcomes going forward.

> “If you want to push a car, you don’t come at it from all directions. Only when everyone lines up behind it can you start moving forward.”

QUOTE FROM THE MATCH

03 FROM CONVERSATION TO COMMITMENT

After a reconfiguration of the agenda, participants engaged in a facilitated exercise to start building an Equally Well International call to action. Breakout groups were tasked with answering four questions: what's the problem and what's the need; what is the vision or future state; what actions will get us there; and how do we work together?

Linda Hanane Mouhamou led a presentation drawing on private-sector strategy and branding principles, alongside examples of non-profits that have applied them successfully, to help participants orient to the exercise. Participants were asked to consider how someone encountering Equally Well for the first time, with no prior context, would understand, remember and act on it. The presentation emphasized building a whole brand rather than a logo, and tying mission, vision, values and calls to action directly to strategy and decision-making. Victoria Erskine connected this framing to Equally Well's communications work.

1 · WHAT'S THE PROBLEM, WHAT'S THE NEED?

PROBLEM	WHAT'S NEEDED
The physical health needs of people with mental illnesses are often overlooked, resulting in poor health outcomes including increased morbidity and mortality, and lower quality of life.	A well-resourced, integrated system that brings physical and mental healthcare together, values lived experience and establishes clear accountability structures.

Additional observations

- The 15- to 20-year mortality gap experienced by people with mental illnesses is core to the problem and a direct consequence of systemic disconnection, not an inevitable biological fact.
- Equitable access to resources is conspicuously absent from many existing systems, with mental health patients routinely denied the same standard of care as non-mental health patients — and that lack of access extends beyond healthcare to nutritious food, opportunities for physical activity and the practical supports needed to use them.

2 · WHAT IS THE VISION OR FUTURE STATE WE WANT TO WORK TOWARD?

Key concepts for a vision

- People with mental illnesses have the same right to life as everyone else.
- “Every door is the right door.” True in spirit, though some urged against metaphorical language like “door” to ensure the vision is concrete and resonant across cultures and languages.
- The current healthcare system denies people with mental illness a full and free life. The vision should be the elimination of that denial.
- Everyone has the same right to the same duration, dignity and quality of life.

AN ACRONYM PROPOSED AT THE MATCH

W	Whole-person care
E	Equitable access
L	Lived experience-informed care
L	Longitudinal — proactive, wraparound care

Out of concern that “longitudinal” might imply continuous clinical oversight, the word was explicitly defined as “a system that remains continuously available rather than one that is continuously imposed.”

3 · WHAT ACTIONS WILL GET US WHERE WE WANT TO GO?

Five pillars were proposed as areas of action for going forward.

01	**International collaboration**	because the problem is global and solutions must be developed and shared across jurisdictions
02	**Data collection**	including the development of indices, KPIs and measurement frameworks to track progress and hold systems accountable
03	**Policy commitment**	making integrated care a central policy commitment nationally and internationally
04	**Sharing successes**	to disseminate what works systemically across the full range of contexts in which integrated care is being attempted
05	**Partnerships**	among and across clinical, research, community and lived experience organizations

CALLS TO ACTION

Act now Include us

Participants added “act now” and “include us” as calls to action — to emphasize the need for immediacy and inclusivity of people with lived experience, researchers, clinicians and community organizations.

Genuine inclusivity requires all voices be heard in real time, with the explicit goal of co-designing systems that work for the whole.

4 · HOW DO WE WORK TOGETHER?

ACTION	PROPOSED OUTPUT
Develop **communities of practice** — virtual networks for sharing presentations, discussing emerging evidence and maintaining relational connections formed during the workshop.	Publish an editorial in a leading psychiatry journal within four to six months.
Distribute leadership so no community of practice depends on a single person or organization. Nobody should have to do everything, and the resource load should be distributed equitably.	Have different movement members take responsibility for different functions — hosting a website, building tools, submitting abstracts, organizing attendance at international meetings.
Diversify the movement. Several participants noted the current group was predominantly anglophone; small organizations, NGOs, lived-experience-led organizations and First Nations communities face significant barriers to attending international meetings.	Make it a medium-term priority to secure funding for less-resourced movement members to participate in future gatherings, ensuring organizations of all sizes are represented.
Include youth in a meaningful way. Younger generations must be active co-designers of the systems and tools being developed, rather than recipients of decisions made without them.	Establish a virtual youth community of practice to enable engagement without requiring travel.
Measure impact intentionally. Patient-reported outcome measures and patient-designed metrics must be central to how the collaborative tracks progress; qualitative data from lived experience carries a depth and specificity quantitative data lacks.	Develop measurement frameworks and tools, including an international scorecard.

04 THE ROAD TO 2028

Looking ahead to the next GLE Equally Well match in 2028, the meeting concluded with a roundtable session in which participants were invited to offer what they will do leaving the meeting to carry its work forward — individually, within their home systems and internationally. Below is a summary of the responses that were put forward.

LEADS ASSIGNED

At the close of the meeting, **Tania Tajirian** and **Christopher Canning** were instituted as co-chairs of Equally Well Ontario going forward.

COMMITMENTS TO ACTION · INDIVIDUALLY

Define what Equally Well means for children and youth in Ireland and establish it as a standing topic among youth.	Niall O'Byrne, Ireland
Take the metformin conversation home.	Brian Higgins, Ireland
Take the match report to meetings and share it.	Mary-Rose van Kesteren, Canada
Strike a multi-organization Equally Well table at CAMH and launch scalable pilots.	Tania Tajirian, Canada
Develop research at Waypoint with integrated care (forensic and corrections) and collaborate with Artemis Igoumenou and CAMH for cross-site research.	Christopher Canning, Canada
Share the Australian metabolic and cardiovascular risk factor scores with colleagues.	Caroline Chessex, Canada

WITHIN MY HOME SYSTEM

Take the scorecard to the minister and convince them to be a champion.	**Brian Higgins, Ireland**
Create a roadmap for the long-term voyage — a five-year plan building on the Australian roadmap.	**Mary-Rose van Kesteren, Canada**
Apply for two grants to host an Equally Well Canada meeting.	**Christopher Canning & Tania Tajirian, Canada**
Lead lived experience activities and get broader representation and diverse voices in Canada.	**Abrar Mechmechia, Canada**
Borrow, steal and elaborate to develop Equally Well communications guidelines on how to work with communities and build capacity.	**Victoria Erskine, Australia**
Connect with Equally Well UK.	**Dina Poursanidou, UK**
Educate and advocate Ontario Shores about Equally Well and operationalize it.	**Natalie Leahy, Canada**
Leverage collaboration between CAMH and the University Health Network and get both CEOs to Ontario's Ministry of Health table to make a statement around priority populations. CAMH has already committed project management work toward a Canadian Equally Well summit.	**Caroline Chessex & Tania Tajirian, Canada**
Bring alignment to where I have connections in primary care.	**Becky van Iersel, Canada**

INTERNATIONALLY

Encourage my minister to talk about Equally Well with ministers from other countries.	**Brian Higgins, Ireland**
Spread the word to more eastern countries, and less developed countries where the gap is even larger.	**Artemis Igoumenou, Canada**
Further develop the international scorecard, communicate why it matters, and leverage it in Canada.	**Christopher Canning, Canada**
Leverage WHO contacts internally at CAMH and convince CAMH public relations to link to the Equally Well International landing page.	**Caroline Chessex, Canada**
Buttonhole people from Canada's mental health commission in Ottawa to support Christopher's event.	**Russell Roberts, Australia**
Strengthen strategic management and implementation maturity by reviewing international Equally Well initiatives to identify shared challenges, opportunities and proven practices.	**Linda Hanane Mouhamou, Canada; Rick Ybarra, USA; Victoria Erskine, Australia**
Build on the mission, vision and guiding principles exercise already completed.	**Linda Hanane Mouhamou, Canada; Rick Ybarra, USA; Victoria Erskine, Australia**

"[Words like] system, structure and healthcare delivery feel external to the individual. I work for the health service. Our purpose is to serve individuals."

QUOTE FROM THE MATCH

05 TOOLS AND RESOURCES

Links and references relevant to Equally Well, as shared during the match.

LEGISLATION, PLANS AND STRATEGIES

- Mental Health Act 2026 Ireland
- Healthy People 2030 U.S.A.
- Connecting for Life: Strategy to Reduce Suicide and Self-harm 2026–2035 Ireland
- Sharing the Vision Digital Mental Health Strategy 2026–2030 Ireland
- Sláintecare Ireland
- WHO Guidance on Mental Health Policy and Strategic Action Plans International
- Sharing the Vision: A Mental Health Policy for Everyone Ireland

FRAMEWORKS

- Brainstorming Critical Shifts Canada
- Co-defining the Dilemma Canada
- Equally Well Advocacy Framework Australia
- Impact: Six Patterns to Spread Your Social Innovation Canada
- Mobilizing Community & Systems Change with Collective Impact Canada
- Ngā Waka o Matariki — Māori Health Strategy New Zealand

REPORTS

- Healing Happens Here Canada
- Older People's Mental Health Physical Health Practice Improvement Project Report Australia
- On Our Own Terms — Systems Change through Lived Experience Leadership Australia
- The State of Mental Health in America U.S.A.

ARTICLES AND PRESENTATIONS

- Diagnostic overshadowing Australia
- Improving primary care for people with mental health or substance use conditions Australia
- From Fragmented to Connected: Whole-Person Data in Action Australia
- Metformin for the Prevention of Antipsychotic-Induced Weight Gain International
- Sustainability? No, it is About Building Durability! U.S.A.

GET INVOLVED

Equally Well grows through partners who bring their own reach, evidence and lived expertise to the work. To join the movement or get in touch, visit Equally Well International.

Act now. Include us.

A EVENT AGENDA

MONDAY, JUNE 1, 2026

9:00 – 10:30 am

Chair: Dina Poursanidou, Tania Tajirian & Christopher Canning

Setting the table

Introductions, match processes, objectives and goals

Purpose. Get to know each other and establish a shared purpose and common understanding of the 2026–2028 arc.

SPEAKERS

All participants

INTENDED OUTPUTS

Introductions and initial connections formed across delegations; shared understanding of match purpose and the 2026–2028 arc

10:30 – 10:45 am — Tea and coffee

10:45 am – 12:15 pm

Chair: Helen Lockett

Power, voice, and the people we keep missing

Lived experience leadership in the Equally Well movement, and how to reach beyond the usual suspects

Purpose. Centre lived experience as a governance and design principle. Surface examples from participating countries and agree on principles for lived experience leadership.

SPEAKERS

Dina Poursanidou (user/survivor researcher, UK); Rick Ybarra (Hogg Foundation, USA); Shizana Arshad & Andy Bell (Equally Well UK, virtual)

INTENDED OUTPUTS

Examples of lived experience governance models; guiding principles for the movement at organizational, national and international levels; guiding principles for a lived experience framework in Canada

12:15 – 1:00 pm — Lunch

1:00 – 2:30 pm

Chair: Russell Roberts

What the world has learned

International learnings and consensus-building; mobilizing global networks

Purpose. Draw on the experiences of countries that have built and sustained national movements to identify transferable strategies for other contexts.

SPEAKERS

Helen Lockett (Wise Group, NZ); Russell Roberts (Equally Well Australia / CSU); Brian Higgins (HSE, Ireland); Shizana Arshad & Andy Bell (Equally Well UK, virtual); Ed Beveridge (RCP); Debra Pinals (U of Michigan / NASMHPD, USA)

INTENDED OUTPUTS

Comparative view of how Australia, New Zealand, the UK and Ireland built and sustain national movements; identification of transferable strategies for the Canadian and US contexts

2:30 – 2:45 pm — Tea and coffee

2:45 – 4:15 pm

Chair: Victoria Erskine & Sylvia Cheuy

Who needs to act, and where

Collective impact, system levels and levers of change

Purpose. Ground the conversation in collective impact frameworks. Build a shared understanding of the system that Equally Well Canada needs to influence, identifying actors, levers and levels.

SPEAKERS

Sylvia Cheuy (Tamarack Institute, virtual); Victoria Erskine (Equally Well Australia)

INTENDED OUTPUTS

Shared learning, approaches and principles for collective impact models; learning how to work together through trust-building, communication and backbone teams; matrix of policy, regulatory, funding, research and advocacy levers in Canada

4:15 – 4:30 pm — Reflections on the day (Padlet and shared in the room)

TUESDAY, JUNE 2, 2026

9:00 – 10:15 am

Moderator: Sanjeev Sockalingam

The view from Ontario

Local innovation at CAMH; data and evidence gaps in Ontario

Purpose. Ground the international conversation in the Ontario reality. Showcase existing physical health initiatives and identify data gaps that limit progress and advocacy.

SPEAKERS

Paul Kurdyak (CAMH / ICES); Tania Tajirian (CAMH); Mahavir Agarwal (CAMH)

INTENDED OUTPUTS

Examples of physical health initiatives and innovations addressing physical health inequities in Ontario; current data systems and gaps in Ontario

10:15 – 10:30 am — Tea and coffee

10:30 am – 12:00 pm

Chair: Helen Lockett

Keeping score

Equally Well scorecard comparative results (Australia, Canada, New Zealand); consensus statement

Purpose. Understand how current mental health and physical health policy documents address physical–mental health integration.

SPEAKERS

Russell Roberts (Equally Well Australia); Christopher Canning (Waypoint); Dina Poursanidou (user/survivor researcher, UK); Helen Lockett (Wise Group, NZ)

INTENDED OUTPUTS

Scorecard baseline assessment of how international mental health policy documents address integration; a shared understanding of how to use this work to mobilize action

12:00 – 1:00 pm — Lunch, with an optional CAMH walking tour from 12:30

1:00 – 2:30 pm

Chair: Dina Poursanidou, Tania Tajirian & Christopher Canning

From conversation to commitment

A call to action and building consensus

Purpose. Translate two days of conversation into a global call to action, communiqué or declaration, and identify what a Canadian consensus statement needs to contain.

SPEAKERS

All participants

INTENDED OUTPUTS

Website and landing page for Equally Well International; feedback on the draft poster for the GLE meeting in Ottawa; global call to action from Canada, Australia, New Zealand, the UK, Ireland and the USA for submission to the WHO, World Psychiatric Association and other international bodies; draft of what a Canadian consensus statement needs to contain, and a process for developing it

2:30 – 4:00 pm

Chair: Russell Roberts & Helen Lockett

The road to 2028

Summary discussion, next steps and commitments leading up to 2028

Purpose. Close the match with documented commitments, a clear plan and named leads for actions. Ensure outputs reach well beyond the people in the room.

SPEAKERS

All participants

INTENDED OUTPUTS

Key success factors for sharing outputs through advocacy networks, professional bodies, researcher networks and the GLE leadership group; agreed next steps with leads assigned; documented commitments by participant, organization and country; GLE World Café report-back

B WORLD CAFÉ SUMMARY

2026 GLE MATCH EVENT HIGHLIGHTS · EQUALLY WELL MOVEMENT

June 2026 marked the third Equally Well match event since 2022. Gathering more than 20 participants from Australia, Canada, Ireland, New Zealand, the UK and the United States, it aimed to mobilize evidence and inform collective solutions for transforming care models and advancing equity — leveraging progress made in different jurisdictions since 2024. The two-day agenda traced an arc from talking and sharing to learning and commitment, with participants focused on forging relationships to drive action and change.

GUIDING PRINCIPLES

Participants agreed that physical and mental health are fundamental human rights, and that the international movement should be guided by the following principles.

- **Equity of access** to physical healthcare promotion, prevention, screening, treatment and continuing care.
- **Multi-level action** built around policies, practices, protocols, programs and partnerships.
- **Genuine inclusion** of experts by experience, building toward lived experience leadership — avoiding tokenism and co-optation, and ensuring psychological safety.
- **Governance structures** that embed diversity of lived and living experience, including fair reimbursement of community members for their contributions.
- **Evidence-based practice and practice-based evidence** to ensure durability.
- **System change** through collective impact.
- **Data collection, measurement and benchmarking** to understand access to and quality of physical healthcare and impact over time, with cancer screening, respiratory and metabolic health, and vaccination as priority metrics.
- **Partnerships and collaborations** across jurisdictions and among service providers.
- **Continuous communication** to sustain a sense of community.

GUIDING PRINCIPLES (CONTINUED)

- **Immediate and short-term actions** to protect and improve the physical health of people living with mental health conditions, and build momentum.
- **Training and accreditation** — building Equally Well principles and practices into allied health, nursing and medical training, education and accreditation standards.

COMMITMENTS AND NEXT STEPS · INTERNATIONALLY

- Develop an international call to action for physical health equity for people living with mental health conditions, while simultaneously including additional countries as partners.
- Increase the number of countries included in the Equally Well International Scorecard, and use this work to benchmark the inclusion of physical health as a priority in mental health and general health policy.
- Advocate for benchmark reporting by the WHO on the physical health of people living with mental health conditions — focusing on cancer screening, cardiovascular health, vaccination rates and regular GP checks as core metrics.
- Increase membership and use the International Collaborative Learning Network to share success, generate initiatives and monitor progress of international and national actions.

COMMITMENTS AND NEXT STEPS · NATIONALLY

- Establish national communities of practice — clinical, policy, research, advocacy and communication — to advance and strengthen the work.
- Bring home the learnings of the event and apply them domestically: prescribing metformin for metabolic health when people are prescribed antipsychotic medications, physical health prompts, cancer screening and vaccinations.
- Elaborate on and develop Equally Well communications guidelines.

COMMITMENTS AND NEXT STEPS · IN CANADA

- Apply for funding and host an Equally Well Canada symposium.
- Strike a multi-organization Equally Well table at CAMH, while making space for individuals and smaller organizations.
- Leverage collaboration between CAMH and the University Health Network and present to Ontario's Ministry of Health on Equally Well — including a proposal to pilot screening initiatives in Ontario that test the proposed cancer screening and metabolic health metrics.

C PARTICIPANT LIST

NAME	ORGANIZATION	COUNTRY
Tania Tajirian	Centre for Addiction and Mental Health (CAMH) / University of Toronto	Canada
Vicky Stergiopoulos	CAMH / University of Toronto	Canada
Artemis Igoumenou	CAMH / University of Toronto	Canada
Christopher Canning	Waypoint Centre for Mental Health Care / University of Toronto	Canada
Helen Lockett	Wise Group, Aotearoa New Zealand	New Zealand
Russell Roberts	Equally Well Australia / Charles Sturt University	Australia
Victoria Erskine	Equally Well Australia / Charles Sturt University	Australia
Rick Ybarra	Hogg Foundation for Mental Health	United States
Konstantina (Dina) Poursanidou	User/survivor researcher	United Kingdom
Mahavir Agarwal	CAMH / University of Toronto	Canada
Sanjeev Sockalingam	CAMH / University of Toronto	Canada
Caroline Chessex	University Health Network / CAMH / University of Toronto	Canada
Alison Freeland	Canadian Psychiatric Association (Chair, Board)	Canada
Brian Higgins	Health Service Executive (HSE)	Ireland
Ed Beveridge	Royal College of Psychiatrists	United Kingdom

NAME	ORGANIZATION	COUNTRY
Linda Hanane Mouhamou	Principal Management Consultant & Advisor in Mental Health	Canada
Natalie Leahy	Ontario Shores Centre for Mental Health Sciences	Canada
Karen Roberts	Public Health Agency of Canada	Canada
Paul Kurdyak	CAMH / ICES / Ontario Health / University of Toronto	Canada
Becky Van Iersel	Waypoint Centre for Mental Health Care	Canada
Barna Konkoly-Thege	Waypoint Centre for Mental Health Care / University of Toronto	Canada
Shizana Arshad	Equally Well UK	United Kingdom
Andy Bell	Equally Well UK	United Kingdom
Abrar Mechmechia	ABRAR Trauma and Mental Health Services	Canada
Debra Pinals	University of Michigan / NASMHPD	United States
Mary Rose van Kesteren	Lived experience researcher	Canada
Sylvia Cheuy	Tamarack Institute	Canada
Niall O'Byrne	Deloitte	Ireland
Andrew Kirkwood	Writer	Canada
Dale Morris	Writer / Communications Strategist	Canada

D

PRESENTATION SLIDE DECKS

Decks presented across the two days of the match follow this page, in the order they were presented.

01	**Lived Experience Leadership in the Equally Well movement: pitfalls and possibilities** Day 1 · Power, voice, and the people we keep missing	Konstantina (Dina) Poursanidou, Independent User/Survivor Researcher, UK
02	**Mobilizing Community & Systems Change with Collective Impact** Day 1 · Who needs to act, and where	Sylvia Cheuy, Tamarack Institute
03	**The View from Ontario** Day 2 · The view from Ontario	Paul Kurdyak, CAMH / ICES
04	**Cancer Screening in Long-Stay Psychiatric Inpatients** Day 2 · The view from Ontario	Tania Tajirian, CHIO and Chief of Hospital Medicine, CAMH
05	**Improving Metabolic Health in Patients with Severe Mental Illness: A Psychiatrist-led Approach** Day 2 · The view from Ontario	Mahavir Agarwal, Centre for Addiction and Mental Health
06	**Equally Well Canada policy scorecard · 2026** Day 2 · Keeping score	Christopher Canning, Waypoint Centre for Mental Health Care