



The Time Has Come: Make It Happen

A mental health **action plan** for Toronto and Peel

Toronto-Peel Mental Health Implementation Task Force

Companion Document
to the
Final Report to the Minister of Health and Long-Term Care

December 24, 2002

The Time Has Come: Make It Happen

A mental health action plan for Toronto and Peel

*Commentary by
The Toronto-Peel Mental Health Implementation Task Force*

This companion document supplements the full report of the Toronto-Peel Mental Health Implementation Task Force submitted to the Ontario Minister of Health and Long-Term Care on December 24, 2002. The Task Force was appointed by the Minister of Health and Long-Term Care in January 2001 with the mandate to develop an implementation plan for the Government's policy document "Making It Happen."

As such, the Task Force's report and this commentary focus specifically on those in Ontario who live with "serious and persistent mental illness" – about 2.5 per cent of the population.

Meanwhile, ten times that number live with some form of mental illness. In fact, mental illness represents the greatest source of human disability in Canada and the world.

PROLOGUE

The Ontario Government set the course of mental health reform in this province with its landmark strategy, *Making It Happen*, which calls for a mental health system that is "accessible, integrated, comprehensive and accountable."

It then created nine task forces to produce detailed plans of implementation. The Toronto-Peel Task Force is one of them. Through our participation in the Provincial Forum of Mental Health Implementation Task Forces, we have benefited and learned from the others.

Our recommendations to the Government take the form of an action plan for change. This narrative briefly describes that action plan and the thinking behind it.

The Minister of Health and Long-Term Care has delivered a clear message. The time for talking about mental health reform in Ontario is over. The time for action is now.

This is a welcome message, an historic opportunity with national implications, an act of leadership, a dream whose time has come.

The Task Force thanks Honourable Tony Clement and Deputy Premier Elizabeth Witmer – Health Minister before him – for their vision. We hope we adequately represent it in our report.

Recently, Minister Clement said publicly that successive governments in Ontario have "neglected the mentally ill" for 30 years. The Romanow Commission sounded the same theme nationally when it described mental health as the "orphan child" of health care.

The Task Force's report positions the Minister and his colleagues in government to turn that page in Ontario – and we believe they are poised to do so.

1. PUTTING CONSUMERS FIRST

As a basis for reform, the Government instructed the Task Force to put consumers first and create an implementation plan for a community-based system of services and supports.

This was music to our ears. The words we penned to that music describe a system of mental health services and supports unified by the philosophy, pragmatism and wide-ranging hopefulness of recovery.

Making It Happen takes mental health off the sidelines and into the mainstream of public policy in this province. Its implementation will take consumers out of the shadows and into the heart of decision-making within the new system itself.

People living with mental illness have a right to the same quality of healthcare as anyone else. And they are not receiving it. This must change.

A Bewildering Maze

The past cannot be prologue. The existing system is really no system at all. At best, it is a set of services assembled through successive, relatively ad hoc and incremental responses to the needs of Ontarians from every walk of life who face the challenge of living with mental illness.

This “system” is egregiously under-funded, hard to understand, severely fragmented and difficult to access. For consumers and their families, it is a bewildering maze. The entry and referral process is unclear, uncoordinated and repetitive.

In Toronto, the fragmentation of services is particularly acute. In Peel, less so. But this is not good news either. There is such a paucity of services in Peel that it is simply easier for people to know where to go for help.

Either way, the result is often poor service, limited and inconsistent levels of coordination among agencies and hospitals, onerous duplication and painful frustration for individuals or families trying to access help of some kind – not knowing what they need or where to turn. Their search too often becomes one of desperation.

Mental health arguably touches every citizen of the province. Mental illness is as physical as a heart attack is emotional. But the subject is steeped in myth and misinformation.

Stigma and discrimination are the number one barrier to recovery, blunting some of the most important instruments of recovery that we have – a welcoming community, a supportive family, a job, a decent place to live and belong, an understanding word or a visit in the afternoon.

We ask our leaders in government – in fact, all communities of interest – to develop a better understanding of mental illness. How many of us know for example that only one of seven critical elements needed to support a person’s recovery is medically-based?

The current level of investment in this non-system is insufficient. Especially for consumers with complex or unique needs and those who are typically under-served due to age, gender, ethnic origin, culture, language, sexual orientation, poverty, education or even diagnosis.

Systemic discrimination is not only a barrier to treatment. It contributes to and reinforces mental illness – making people ill, keeping them ill. People living with serious mental illness have told us that the effects of the stigma and discrimination they experience is often much worse than the experience of the illness itself.

The mental health system in Ontario is plagued by shortages of qualified staff and by insufficient use of evidence-based practices. Unbelievably, in this information age, Ontario caregivers lack the resources and the culture of cooperation even to give consumers and their families decent, consistent information.

This is a crying shame.

Cold Stare of Stigma

Barriers are everywhere. One is the insufficient amount of inter-governmental collaboration, a fancy way of saying that people in government don’t talk to each other enough – or at all sometimes – which makes it hard to bring about better ways of serving consumers-in-need.

The “system” is disorganized with little connection and coordination among its various parts. Municipal housing bylaws and income support disincentives haunt those with mental illness and their efforts to lead their own lives.

The Ministry currently funds 83 organizations to supply mental health services and supports in Toronto and another eight in Peel. Each of these, though, circles in its own orbit around Queen’s Park.

Meanwhile, there is the cold stare of stigma and discrimination.

The mythology of mental illness has an iron grip on the way many otherwise logical people perceive the subject. This mythology holds –

- That people living with serious mental illness cannot recover. This is untrue.
- That they are unable to work. Also untrue. And yet 85 per cent of those living with serious mental illness are unemployed.
- That they are violent. One of the most pervasive beliefs about people living with serious mental illness, this is also untrue. In fact, when provided with the right

supports and treatment, people living with serious mental illness are no more violent than anyone else.

- That consumers are helpless. Spectacularly untrue.
- That illnesses of the mind have no connection to those of the body. Provably untrue.

Beyond all doubt – scientific, ethical or otherwise – the mind and body are a continuum which defines the human person. This then should be reflected in the healthcare system itself. But, so far, it isn't.

Why do we need mental health services that function as a system? For the same reason we need health professionals, hospitals and community agencies to function like a team. The care provided to people living with mental illness must be seamless, from inpatient care through to community support. Solutions beyond any one person's grasp are often within the reach of all.

Mental and physical illnesses are similar, but also very different. Mental illness is often chronic and episodic – and support is needed not only from the healthcare system but also from within the community.

We now know that people living with mental illness can and do recover. We also know that to support people in their recovery, significant emphasis must be placed on areas that aren't normally thought of when discussing recovery from a physical illness.

In addition to high quality clinical care, consumers need access to a range of community-based supports – help to secure and maintain a safe, affordable place to live, find and keep a good job, return to and stay in school, and re-establish and form new social connections and friends. Without support in these areas, clinical care can have very little impact.

In a way, it is really just common sense – you wouldn't expect someone to successfully battle cancer if they didn't have a comfortable home to live in, the ability to take paid time off work for treatment, and supportive friends and family members to stand by their side and help them fight the good fight. These things are usually just taken for granted. However, because of the nature of and the stigma and discrimination surrounding mental illness, these are often the very things that are lost by people living with mental illness – making recovery even more difficult.

Mental illness has suffered from the heavy burden of stigma. This is a barrier to recovery. But it has also contributed to the inattention and low priority which consumers have received from successive governments and from the public at-large.

This is, essentially, the point Minister Clement so powerfully made earlier. A well-functioning, integrated and properly funded mental health system can help change it – and must.

Distant Neighbours

Toronto and Peel are neighbors. But their capacity to deal with the crisis in mental health differs widely.

In Toronto, hospital and agency services are concentrated mainly in the south quadrant of the city and while there is some inter-agency coordination, there is not nearly enough. In Peel, there are a significantly smaller number of providers, community psychiatrists and family physicians – and significantly less service capacity overall.

Meanwhile, in both municipalities:

- The treatment and support gap is severe for those who live in poverty, who have less schooling, who don't have a job, or who are racial, ethnic and linguistic minorities.
- Middle and upper income consumers also find that their comparative wealth and political or social connections aren't worth an awful lot in scaling the systemic cultural and personal barriers to basic care, let alone recovery.
- While too little mental health service capacity is a formidable opponent to the development of an organized and responsive system, so is the lack of a system to consistently match consumers to the particular level of care and set of services and supports that they need. Today, some people get more help than they need, and others – many others – get far, far less.
- Neither Peel nor Toronto has a comprehensive information, referral or assessment system to guide consumers to caregivers or vice-versa. This is in an age when everyday, our society conducts millions of complex business transactions electronically but has yet to harness technology to simply coordinate the care that is delivered to people living with serious mental illness.
- Thousands who don't get the help they need from so-called formal services turn instead to family, friends, priests, rabbis and ministers – anyone who will ease their desperation.
- The result is an informal network of caregivers, heroic people doing what they can for those they love. If governments have neglected those with mental illness in this province for 30 years, so too have we abandoned their families, friends and communities.

This must all change.

Themes of Action

In our report, the Task Force makes scores of specific recommendations clustered around several thematic action plans. Overall, however, our implementation plan is an ecology of solutions to achieve six specific outcomes. Everything else is a means to these ends.

1. Increased service capacity in targeted areas over time so that consumers receive the services and supports they need, when and where they need them.
2. Creating and sustaining housing, education and job opportunities, and social connections as key elements to support consumers in their recovery.
3. Dramatic improvements in the accessibility of the system, so that consumers and families find it easy to access, exit and re-enter the system as needed.
4. Enabling the system to serve those with especially complex needs by increasing the skills and capacity of both general and specialized service providers, and by strengthening the linkages between and among service providers, service sectors, Ministries and levels of government.
5. Giving consumers and their families an influential voice in shaping and running the system.
6. And achieving greater community and societal understanding of mental illness itself. This is an essential building block for future success.

In fact, the Task Force's recommendations require us to adopt a value system which promotes human understanding of serious mental illness and the creation of a system wedded to the concepts of recovery, responsiveness and accountability.

The World We See

What kind of system would that be – what kind of world would it project? For openers, let's be clear about one thing. In our advice to the Minister, we are not trying to create Cadillac out of orange crates – or forge a gold-plated system from a fiscally-impooverished one.

To the contrary. Mental health reform is about the stuff of life, helping those living with serious and persistent mental illness enjoy the rights and responsibilities of full citizenship – and the simple joys of independent living.

Our implementation plan sees a world where those with serious mental illness routinely, not rarely, live in their own apartments or houses with neighbours all around them.

We project a time where those living with mental illness will routinely, not rarely, engage in meaningful activities which they have chosen for themselves.

People living with mental illness have good days and bad. As do we all. The defeat of stigma will allow them this normal experience without being punished for it.

People with mental illness represent every walk of life. Our implementation plan simply contemplates giving each the opportunity not to be defined by their illness, but by who they are – their preferences, their strengths, their capacity to learn and contribute to their society.

Our plan calls for more than \$250 million of new money for the mental health systems in Toronto and Peel over five years.

This will ultimately go to building a mental health system where compassion and common sense become affordable and productive alternatives to disorganization and indifference. This is a worthwhile investment for the Province to make.

2. THE RECOVERY AGENDA

Mental health is a complicated topic. It does not fit conveniently into a single portfolio of government or envelope of funding. Champions with clout have been hard to find. We may have found one in Minister Clement. If so, he will make history.

Making It Happen could emerge as the most significant health and social policy initiative in Ontario of the past 30 years.

The implementation plan we have submitted to the Minister is really a roadmap to hope and recovery for people living with mental illness and their families. And to use this roadmap wisely, let's understand recovery for what it is – and what it is not.

First and foremost, it is a realistic proposition. People can and do recover from mental illness. Mental illness is not a life sentence.

Recovery is a work in progress, a journey not a destination. It is a state of well-being – the nature of which must be determined by the individual – in his or her own case – not by the system.

Self-help and peer support is part of the recovery process. Recovery is personal and unique. This need not surprise us. Human beings are not all the same. Recovery is also a democratic concept – it promotes freedom of choice.

The promotion of recovery is the ultimate expression of putting the consumer first in the design and delivery of mental health services and supports.

Making It Happen says this: “*The consumer is at the centre of the mental health system... Ontario's new mental health system will deliver services to people when they need them – where they need them.*” These words have driven our efforts.

SkyDome to Capacity

In Toronto and Peel, mental health reform means a system which can engage its clients in many languages, which respects different cultures, which serves people in diverse community settings.

Well that it should. Consider this: one in five people in Toronto and Peel live with some form of mental illness.

That's nearly 600,000 people – people from every walk of life, many of them children, many more working parents, and many seniors. Mental illness has enormous social and economic implications.

Put another way, people living with mental illness – most of whom are un-served and untreated by the current system – could fill the SkyDome to capacity a dozen times a year – year after year. We must recognize the seriously disabling potential of even mild and moderate forms of mental illness.

Like any illness, left undiagnosed and untreated, mental illness can produce human disability on a large scale. Depression is the leading cause of disability in Canada and the world today.

Recommendations for Action

The Task Force has made concrete recommendations for action to the Minister to create an outcomes-focused, community-based, consumer-centred, comprehensive, accessible, and integrated continuum of services and supports for those living with mental illness.

Some of what the Task Force recommends:

- A new system based squarely on outcomes – together with implementation of the mechanisms and processes needed to hold everyone in the system accountable for achieving them.
- Articulated standards of care which are widely understood, widely practiced, and not compromised.
- A new information and referral system which allows consumers and their families to get easy access to the services and supports they need when they need them – quickly and efficiently – regardless of their point of entry. A regional, toll-free information line will connect consumers directly to local crisis response services, peer support groups, and designated information and referral services in each local area.
- Cultural consultation and mobile interpreter teams to serve Toronto and Peel's extremely diverse ethnocultural communities. People with any kind of serious illness will naturally revert to their first language to express themselves – and simply to cope.

- Improvements in assessing and matching consumers to the services and supports they need, eliminating duplication, breaks in service, and consumer frustration.
- Clearer and differentiated mandates for all community agencies and hospitals so everyone in the system knows where to go for the kinds of services and supports that they need.
- Comprehensive and well-organized networks of community-based, ambulatory, and inpatient services and supports in each local area. Particular emphasis will be placed on improving the coordination between hospitals and community agencies through formal agreements and protocols – so that consumers and families can finally stop “falling through the cracks” when moving from one part of the system to the other.
- An increase in the quantity and quality of mental health services delivered by family physicians and community health centres.
- An increase in Peel’s intensive case management and acute inpatient bed capacity and an additional “Assertive Community Treatment” (ACT) team in Brampton.
- Increased intensive and specialized mobile outreach team capacity in both Toronto and Peel. Particular emphasis will be placed on enhancing early intervention and prevention and seniors-serving team capacity in each local area.
- Piloting of what are called “residential treatment facilities” – high support but home-like settings located in the community for people who otherwise would need to receive their care as inpatients in specialized psychiatric hospitals
- Everyone in the system being educated about the critical role of housing in the process of recovery. A place to call home generates security and independence for those living with mental illness. We will build toward an era of accommodation through understanding.
- The creation of 3,200 units of new housing in Toronto and 2,150 units in Peel specifically geared to the needs of those living with serious mental illness.
- At the same time, the removal of disincentives for housing of this nature inherent in existing municipal bylaws.
- Provincial and regional initiatives to promote meaningful work, vocational training and educational opportunities for those living with serious mental illness – particularly in those geographic areas which receive little to no service right now.
- Replacing work disincentives with work incentives. Under the present system, people living with mental illness cannot accept a job without the fear of losing the income supports they now receive from government. People then end up with no income if the job fails to stick with them or they with it.

- Adjusting income support programs to work better for people living with serious mental illness by providing incremental reductions in assistance over time as job-related income is sustained and grows, and by dramatically simplifying rapid assistance and reinstatement processes should illness recur.
- More alternative businesses which are run by consumers, hire consumers and which deliver quality products and services to the wider market place – functioning as legitimate business enterprises.
- Increased capacity and more equitable distribution of drop-ins, social and recreational programs, and consumer and family peer support initiatives, anchored by well-understood “best practices.”
- Strategies to ensure an adequate supply of skilled and competent mental health professionals and care providers whose know-how is routinely, not rarely, updated in concert with expanding knowledge in the field.

The 3 R's of Mental Health

The Task Force's recommendations for action do something else – they introduce Ontario to the “3 R's” of mental health:

- Recovery, the governing principle and philosophy;
- Responsiveness, the imperative of service delivery;
- Responsibility, the requirement to really achieve the outcomes which stimulate this historic initiative.

3. THE LEADERSHIP FACTOR

All said and done, without leadership, vigilance and courage, this mission fails. Therefore, our implementation plan sets out a practical structure within which to house these essential ingredients of success.

Reform efforts over the years by successive governments have failed to bear fruit. From this, we have learned an important lesson. Reform will *not* just happen. Goodwill alone is not enough. An active and positive catalyst is needed to drive implementation of the Task Force's recommendations.

To provide this leadership and drive, we propose the formation of a regional mental health board in each of Toronto and Peel to govern the transition to a new system and, from there, the new system itself.

We propose the creation of four local service areas in Toronto and two in Peel under the leadership and management of the mental health board in each municipality. Each local service area will be responsible for delivering a comprehensive range of easy-to-access and well-coordinated mental health services and supports to the consumers and families in that community.

We propose that the Government of Ontario redefine the Ministry's role to focus on policy, standards and overall funding authority. Each regional board would report to the Ministry.

We propose that regional boards operate at arms length from the Government and assume responsibility for comprehensive mental health funding envelopes for Toronto and Peel.

We propose that the regional funding envelopes include funds for specialized psychiatric services, hospital inpatient and outpatient programs, and community mental health programs.

We also propose including sessional fees and other incentives to increase physician care of people living with serious mental illness. We propose incentive funds for consumer participation in system development and leadership. And we propose funds for evaluating the outcomes of mental health system reform.

We propose a purchaser-provider split – a management term which means that:

- The regional boards will not deliver services directly but will purchase them from community mental health agencies, hospitals and other providers.
- Within the new system, agencies and hospitals in each local service area will forge networks and alliances through which to deliver mental health services and supports to consumers and families, in collaboration with others and according to clearly defined service agreements and protocols.

The purchaser-provider split will thus establish clear lines of accountability for everyone in the system.

At the same time, funding priorities will be established locally through a process of community consultation – listening and responding to consumers, families and providers. This process is fundamental to the work of the boards.

A Responsive System

In the first instance, the members of these boards will be appointed by the Minister on the basis of recommendations from the local community.

The goal: balanced representation. To that end, consumers and family members will sit on the boards as voting members, representing at least 35 per cent of the total membership. This will give them an influential voice.

Service and support providers that are funded by the regional boards will not sit on the boards so as to avoid even the perception of conflict of interest. A wide range of mechanisms will be put in place to ensure service provider and professional input to the boards' decision-making process.

Our implementation plan calls for the creation of Community Advisory Councils which will draw upon local consumer, family, service provider and professional experience.

Consumers will be supported to develop as a community and to produce more leaders to provide a strong consumer voice in the boards' on-going initiatives.

We also call for the creation of an Office of System Responsiveness within each board – driving the system to meet the needs of *all* consumers and families and staffed by individuals who duly reflect the communities which the boards serve.

We recommend the creation of an Office of Consumer and Family Affairs – effectively an ombudsman to prevent the seepage of bureaucratic, ineffectual or discriminatory behavior into the system. This office would be connected to the Boards but function independently of them.

As to the matter of overall executive leadership, each mental health board will have its own CEO or executive director – a person who is qualified for the position, obviously, but also one who embraces the spirit and not just the mechanics of the recommended change.

The recruitment process, therefore, must scan for the appropriate philosophical outlook, inclusive instincts and strength of character, as well as the executive skills that will be required.

Once chosen, this individual will be expected to foster and protect the evolution of a belief system to create and sustain a culture which marries systemic effectiveness with compassion and responsiveness.

Governance is all-important. Predictably, each board will have vital standing committees. But we provide for fewer rather than more to guard against bureaucracy, meeting fatigue and mandate drift.

At the same time, the boards must be funded to conduct on-going outcome evaluations. This is critical to sustaining the principle of accountability – the heart and soul of an outcomes-based system.

The Task Force's mandate did not include addictions and the addiction community did not have an opportunity to participate with us as an equal partner. This should be remedied as soon as possible.

That said, given the very strong link between mental health and addictions issues, the Task Force believes strongly that addictions and mental health should be properly integrated.

A process is needed to determine if, when and how the addictions sector could become part of a more comprehensive regional mental health and addictions board.

4. THE IMPERATIVE OF ACCOUNTABILITY

By recommending the regional board concept, the Task Force is not tempting the fate of an unintended consequence – that is, we are not creating a new, top-heavy and cumbersome bureaucracy, in effect, another level in the system. Nor will we be segregating mental health from the rest of the healthcare, social services or justice systems.

Rather, we seek to clarify roles and responsibilities, and bring coherence and voice to a system that has languished on the sidelines of the health system far too long.

We examined carefully other alternatives to the regional board approach. The fact is this: the transition to a new system – and the implementation of “Making It Happen” – won’t happen without the presence of a strong, resilient, duly empowered and catalytic force.

This is the essence of the Regional Board concept. Properly staffed, well-governed, accountable, connected to the community and courageously led, these boards will make *Making It Happen* – happen.

These boards will draw their ideas and their inspiration from the local community. This is their constituency. The boards will bring clarity, coherence and cohesion to the transition process and to the new system itself.

Quite decidedly, the boards will not hoard information or foreclose people in one part of the system from consulting with each other or with the Ministry itself. The boards will be inclusive as a matter of policy and practice.

Further, the boards must not only encourage but ensure strong linkages with family physicians, other general healthcare providers, community psychiatrists, other parts of the healthcare system, universities and colleges, and the social services and justice systems.

The boards must bring coherence to the mental health system – making the system more understandable to other players in the healthcare and associated systems – and therefore, easier for everyone to connect with and access.

Accountability Sequence

That said, the Ministry and the boards will define accountability and responsibility, as well as the processes serving those key principles. This will open up the system to new ideas and new energy. It will counter the seeding of turf wars and territoriality. There will be business plans from and annual performance evaluations of every player in the system.

Accountability is more than a concept. It must have teeth. It starts with the Minister and Ministry of Health and Long-Term Care setting out broad policy and the delivery standards that must be met.

The Toronto and Peel Boards would then submit to the Ministry a business plan designed to meet the Government's policy objectives, reflecting the community's needs, demonstrating value for money, and focusing largely on outcomes, giving the board flexibility to meet changing needs during the year.

Each board and its staff would then be responsible to implement the approved plan.

Meanwhile, a system of funding and performance contracts, service protocols and annual business plans with and between local service and support providers would assure the boards and the Ministry that the purposes and objectives of the new system are being carried out.

Outcome evaluation will become the norm, and will guide future business plans.

In this context, we note the critical role to be played by the World Health Organization-designated Centre for Addiction and Mental Health (CAMH), in bringing together – in one accomplished setting – treatment, education and research.

All in all, this constitutes the imperative of accountability – a rock hard foundation for a new mental health system that is open not closed, that is receptive to new ideas, not suspicious of them and that welcomes the voices of consumers and their families as the sound of progress and insight.

5. PREMIER'S COUNCIL ON MENTAL HEALTH

If our goal is to create a universe of services and supports unified by the principle of recovery, there are three other stars in that firmament.

One is the promotion of mental health and prevention of mental illness through public education.

A second is the on-going recruitment and retention of a committed, culturally-competent and highly qualified mental health workforce. A third is the development of the information systems needed to support the process of accountability.

And to illuminate these stars, the Task Force recommends the formation of a Premier's Council on Mental Health – a body with access to the highest levels of government – to champion such issues.

Where the regional mental health boards are community-based, the Premier's Council would be a forum to drive province-wide issues, act as a sounding board for the Premier and

Cabinet and raise both the profile and the voice of mental health across the province – to serve, in effect, as something we might otherwise call “Mental Health Ontario.”

Mental illness is more than a private burden. According to new estimates by the Global Business and Economic Roundtable on Addiction and Mental Health, and as reported in the Toronto Star, mental illness in Canada costs the economy – and that’s just the economy – more than \$30 billion a year.

The Roundtable, led by business executives, has made prevention and education – in effect, mental health promotion – a top priority. So should Ontario. The Premier’s Council will make sure we do.

The proposed Premier’s Council will promote these objectives:

- Sustained public education initiatives as a means of promoting good mental health, producing more supportive communities and eliminating stigma and discrimination;
- A human resources skills, supply and competence agenda so vital to sustaining high standards of service and care; and
- The nurturing of information management to support a system which provides compassionate care, a consumer-first ethic of operation, and which is accountable for the outcomes it achieves.

The moral and economic case for change

Mental health reform is most timely. The Government and the people of Ontario already have a big stake in mental health. That said, funding for community mental health services has been frozen for a decade. This is both shameful and short-sighted, as the costs saved in this way simply show up elsewhere in the system. Even at that, the Ministry still spends \$2.7 billion a year on mental health services and supports.

Measures and mechanisms are needed to manage this investment better. The Premier’s Council would be one mechanism – and a very important one. But our stake in mental health deepens in other ways.

Mental illness accounts for the longest average length of stay in hospital – 37 per cent higher than the next highest category of illness – and for about one quarter of the 34 million hospital days recorded in Canada each year.

As mentioned above, mental illness in Canada costs the economy more than \$30 billion a year.

Untreated mental illness adds considerable expense to other publicly funded services as increasing numbers of people with untreated mental illness end up in poverty, in trouble with the law, or both.

And that's just a snapshot of the economic cost. The human cost is even more stark.

Approximately 2.2 million people in Ontario will experience mental illness, and 330,000 of these people will live with a serious mental illness.

Beyond the symptoms and distress caused by a serious mental illness, consumers and families can face discrimination and neglect, unemployment and poverty, homelessness and social isolation.

As mentioned earlier, approximately 85% of people living with a serious mental illness are unemployed and many lack safe, affordable housing.

The stigma and discrimination that often accompany mental illness isolates people and deprives them of basic human dignity and their fundamental rights of citizenship.

The human imperative for change is undeniable.

The good news is that evidence from other jurisdictions indicate that investments in community-based treatment and support services, early intervention and prevention programs, the creation of organized and coordinated systems of care, and public education to increase community awareness and understanding, can significantly increase consumers' quality of life *and* reduce costs to and pressures on the formal mental health care and associated systems.

All of which justifies such investment on both moral and economic grounds.

EPILOGUE

The Task Force consulted widely. Much of what we have recommended to the Minister flows from that consultation and from the experience and expertise of our Task Force, sub-committees and working groups.

Admittedly, we encountered skepticism as to whether the government really means business given the number of false starts in the past. We overcame that – even among ourselves.

Not surprisingly, though, like everything in life, the proof will be in the pudding and the first stir of this new pudding will be the enactment of legislation and a corresponding commitment of funds.

From there, the real job begins. Shifting attitudes, changing systemic cultures and – let us not forget this – truly believing in the people that this system is destined to serve.

To face this humbling task, we might draw inspiration from George Bernard Shaw who once wrote that some see the world as it is and ask why; others see the world as it might be and ask why not. It is they who shape the destiny of humankind.

Minister Clement and the Deputy Premier have both asked why not – why not a mental health system which heals the ache of millions and makes Ontario an even better place to live.

Why not indeed? Let's make it happen.

THE TORONTO-PEEL MENTAL HEALTH
IMPLEMENTATION TASK FORCE

Honourable Michael Wilson, Chair