

EXECUTIVE SUMMARY

The Northeast Mental Health Implementation Task Force is pleased to present this final report, *The Time for Change is Now: Building a Sustainable System of Care for People with Mental Illness and Their Families in the Northeast Region*. Building on the work of hundreds of people over the last twenty years, the report presents a comprehensive plan for redevelopment of adult mental services. Redevelopment is necessary so as to bring together all services and supports into a continuum of care for people who have mental illnesses, and for their families and caregivers. Implementation of Ontario's mental health policy calls for a fundamental shift to supporting people in their communities and assisting them with their recovery from mental illness. Putting the person at the center of the system means that services must focus on meeting needs directly so that personal recovery goals are defined and achieved. Embracing best practices of multidisciplinary teams and shared care models will see people having their needs met in a timely fashion, as close to home as possible, by the appropriate mix of providers, in the least intrusive way. Most critical is development of an individualized assessment function within the new system so that people's mental health problems and needs are determined early and efficiently, thereby increasingly the effectiveness of treatments and interventions, and fostering recovery in a supportive and respectful manner.

Traditionally, the four solitudes of adult mental health services in Ontario have struggled to work together to meet the needs of citizens who experience mental illness. For many decades, the provincial psychiatric hospitals had the expressed mandate to care for people, providing comprehensive institutionalized care. During this historic period, communities lost touch with their responsibility with regards to these citizens – content that the people were being cared for away from the community. Changing social perspectives including civil rights movements, improvements in medications and other processes contributed to the re-emergence of the community's role in assisting people who have mental illness. Correspondingly, community mental health services grew in number, type and scope. Governments in the last 50 years responded to these trends, publicly funding new programs through provincial psychiatric hospitals, Schedule 1 hospitals offering acute mental health treatment, community hospitals, community-based agencies, as well as consumer and family initiatives.

Despite this expansion of mental health programming, there has been one major weakness in the mix of services. They have simply not come together into a comprehensive system to well

serve people with mental illness and their families. Individuals and families, who have raised their voices and concerns through twenty years of mental health reform consultations, are clear that the current array of services are poorly coordinated, often working at cross purposes, hard to navigate especially when one experiences a mental health crisis, sometimes demeaning and disrespectful of personal strengths and goals, and are not focused on much beyond alleviating symptoms of mental illness. There is competition among providers for scarce funding dollars, as well as duplication, confusion and gaps in their respective roles.

At the same time, there is a growing body of evidence that demonstrates the efficacy of best practice approaches in the mental health field. People with mental illness, family members, service providers and experts have all called for the use of practices with demonstrated effectiveness. Implementation of these practices requires an evolution in the delivery of publicly funded mental health services to a model of continuous quality improvement. Standards, education and training opportunities, sustained research and translation of findings into policy and practice are required.

The costs of mental illness to Ontario and Canada are high. There is a direct impact on local, provincial and national economies: mental illness is a leading cause of disability. At least 20% of all Ontario citizens have a mental illness and the other 80% are indirectly affected (*Report of Mental Illness in Canada*, 2002). The economic cost of mental illnesses in Canada was estimated to be at least \$14.4 billion in 1997 (Stephens & Joubert, 1998). This figure represents only a small, measurable portion of the economic burden of mental illness. “Among the measurable components of economic burden are health and social service needs, lost productivity and reduced productivity, impact on families and caregivers, levels of crime and public safety, and the negative impact of premature mortality” (World Health Organization, 2002). In addition, billions of dollars are being spent dealing with the consequences of untreated mental illness, rather than spending wisely on services oriented to recovery. The total range of costs on individuals, families, communities, the province and the country is wide, long-lasting and huge. Overall, the direct and indirect costs of mental disorders as a proportion of Ontario’s economy are high, a fact that has yet to be acknowledged in the public and private sectors.

The importance of creating efficient, effective, humane and accountable systems of care in Ontario cannot be under stated. This report, along with those of the other eight mental health

implementation task forces, and the report of the Provincial Forum of Mental Health Implementation Task Forces provide the details and rationale for change. Expansion is required to ensure that all Ontarians who need mental health services receive care. But expansion alone is not sufficient. Development of a system infrastructure to bring the numerous partners into a well-defined and functionally honed system of care that focuses on the consumer is overdue. This lack of system infrastructure means that mental health care continues to suffer in relation to other parts of the Ontario health care system. A sustained and long-term funding commitment is required to redress this imbalance.

Ontario must implement a proactive mental health policy to help people maintain their functionality – to have homes, jobs, friends, ambition and independence. Ensuring that everyone receives care will require a substantial up-front expenditure. Building public support as well as system capacity to provide services will take time. Still such an investment will bring positive returns to Ontario: most important we will provide hope for Ontarians who are too often viewed as a liability than an asset. By offering a well-defined and effective system of mental health care we will lower criminal justice, public health and safety costs. We will no longer overburden acute health care, but instead make efficient use of specialized psychiatric expertise and beds. We will enhance productivity in the business sector and focus the efforts of public services. Overall, we will increase the quality of life of Ontarians.

As with physical health care, the value of quality mental health care is shared throughout our communities. Providing quality care is a community responsibility. Ontario must support the foundation of a sustainable and successful public mental health system focused on people with mental illness being part of the community. The public will be willing to invest in this system once they fully understand the costs and consequences of not treating mental illness. Public education is vital in terms of addressing community inclusiveness and responsibility thus contributing to reduction in the stigma and myths attached to mental disorders. There are immediate lessons to be shared from the pilot, mental health public education project, *We All Belong*, the Ministry funded in Northeastern Ontario, and a unique opportunity to take this program province-wide.

There are many reasons to be hopeful here in the Northeast and throughout the province. The mental health implementation task force process has once again revealed that there are many individuals with unwavering resolve, who are working to provide the highest quality of care

possible. They creatively piece together responses across the existing service gaps and work together to provide people who have mental illness with some coordinated care. There are examples of innovative and effective programs that merit validation and wider implementation. We have leaders with knowledge, expertise and vision to make mental health reform a reality in Ontario.

We can solve the problems facing Ontario's mental health system. We require the commitment and leadership of the Government and its Ministries to build a world class mental health system. It is time to honour the promises made through twenty years of mental health reform dialogue. We need to provide adequate housing, employment, treatment and supports – services that were provided in institutions and need to be provided in our communities. People with mental illness need to be acknowledged for who they are – our mothers, fathers, daughters, sons, sisters, brothers, friends, neighbours, colleagues and fellow citizens.

Highlights of the Northeast Mental Health Implementation Task Force Reports

The highlights of the Northeast mental health system design are:

- ✓ Operationalizes a client-centred system of care with primary emphasis being on providing as many supports and services as close to home as possible. The principle objective of mental health reform to improve care for people with severe and persistent mental illness will be achieved in this structural organization through defined accountability, heavy reliance on coordinated assessment and care in the community, appropriate housing and employment options, family supports and a visible and increasing role for consumers and families to participate in all levels of the system.
- ✓ Creates a system with a continuous appetite for research, development and innovation at all levels while searching for ways to ensure debate and educate the public.
- ✓ Reflects the roles for key components of the regional mental health system including the regional mental health facility, Schedule 1 hospitals and community-based integrated mental health agencies. Service duplication and overlap in jurisdictions and catchment areas will be eliminated. The components and their relationship to each other must be

clear and transparent so that people with mental illness and their families can understand and easily navigate the system.

- ✓ Enhances the district mental health care continuum resulting in people being supported and treated as close to home as possible according to personal needs thereby reducing the reliance on inpatient care.
- ✓ Increases opportunity for community tenure for people who have mental illness through delivery of a sustained public education campaign that addresses community readiness and begins the change process to eliminate stigma.
- ✓ Identifies four key client transfer points in the system: the connections between the levels of care that require clear operational agreements/protocols, as well as joint data systems, planning mechanisms and evaluation. Emphasis is on the service partners in the system to assist people to move between service components in a simple and timely fashion based on clearly established clinical criteria.
- ✓ Place priority on access for people who have severe and persistent mental illness as well as accommodates first line services, prevention and early intervention for those who are at risk of developing more serious mental illness.
- ✓ Emphasizes the importance of developing consistent and streamlined access points, assessment criteria and processes across the region through implementation of integrated mental health agencies according to the levels of need model. This speaks to clear determinants for assessments and triage, titration of services and supports based on the person's changing needs.
- ✓ Simplifies the interface of the mental health system with other sectors like children's mental health, primary healthcare providers, housing, education, criminal justice system and so forth, so shared care approaches for clients are feasible, and system management and planning are efficient.
- ✓ Calls for development of a client linkage information system to support appropriate transfer of information as people move between levels of service within the system.

This information system is central to the communication function between system components and critical in achieving continuity of care. Also, such a system will allow measurement of performance and be a vital tool in the overall management of the reformed system.

From the perspective of service delivery, the Northeast mental health system design calls for the creation of integrated mental health agencies at the community level. This is a key response to the policy direction for streamlining access and service delivery. All districts in the Northeast lack a comprehensive continuum of care and further service development is hampered by the fragmentation in program sponsorship that is varied throughout the region. Furthermore, people in need of care are not being assessed in a holistic manner resulting in receipt of too little or too much care in some cases, and inappropriate care according to need in others. Responsibility for care delivery and coordination is defined as a central objective for the integrated agencies, clearly placing this role at the key point of interface with people who have mental illness and their families. The burden of mental health care must be shared more broadly beyond the medical partners of the system, and the integrated agency provides the mechanism to ensure care continuity, coordination and prompt and appropriate delivery of care.

In the Northeast, the integrated mental health agency is also important in responding to the unique and demanding factors that impinge on the delivery of health care. Distance, weather, declining populations, low population density, limited social safety net, challenges in recruitment and retention of mental health care staff and professionals, overall poorer health status of the population are some of the considerations that must be factored into the cost of care in the North. Mental health care at the community level is fragmented in many of the districts and there is competition among providers for the limited funding that is available. Streamlining service governance is necessary to create opportunity for improvements in service delivery to consumers and families. The system vision must be supported through focused leadership of boards of directors and clear paths of accountability to both the community and the mental health system especially in the immediate future when considerable change is expected. Common and best practices are required at the level of the integrated agencies so that consumers and family members can be assured that they are able to access the appropriate type of care that is needed in a timely fashion no matter where they reside. Such implementation requires defined and sustainable mechanisms for staff development and

training. Overall the system requires a smaller number of dedicated partners focused on delivery of state-of-the-art care.

This mental health system design provides role definitions for mental health system partners, a key requirement for building a regional “system” of care. Clarification of roles is required as existing partners are still unclear of who is doing what in relation to people with mental health needs as well as where the accountability and ultimate responsibility for providing care lies. System operation requires some means to foster routine and ongoing interaction of the partner organizations, and in turn, support daily contact of staff who must work proactively and creatively across the levels of care to truly support individuals in recovery. System operation also requires maintenance and further refinement of the overall vision and the leadership with regards to the position and importance of mental health care in the overall health care system.

To that end, this report along with those of other Task Forces, raises the question on how to provide overall system management so as to build regional and local systems of care but also ensure that all Ontarians have the same access to the services they need. Full development of a sustainable mental health system in the province requires focused leadership, consistent attention and aggressive effort. While the Ministry of Health and Long-Term Care has been entrusted with the leadership of the system, the degree to which it is funded and organized to develop a community-based system of care is open to examination.

The Ministry of Health and Long-Term Care recognized the need to get out of direct delivery of mental health care in accepting the advice of the Health Services Restructuring Commission to divest provincial psychiatric hospitals. The Ministry has also worked hard over the last 15 years to develop a proactive policy for mental health reform. There has been limited success in taking that mandate forward through government processes to obtain long term funding to support system development and change. More recently, the Ministry has been reorganized through the creation of regional offices in attempt to move system management decisions closer to the people being served, however these offices have not been empowered to manage the regional health care funding envelope.

The Ministry of Health and Long-Term Care has an important leadership function that must focus on setting standards for service, driving the debate on how to build a continuously improving mental health system and enhancing the cost-effectiveness of local programs. The

Ministry is the advocate within government for adequate funding of mental health services and promotion of efficient spending. The perception is that mental health services are seriously under funded – the question is what percentage of need are we meeting? This question is hard for the Ministry to answer because it does not have the data to determine how many people are currently being served or are in need of service. There are other funding concerns that must also be solved: there is no funding formula for mental health in the province and funding is still determined on an annual basis. There are inequities in both availability and quality of mental health care across regions. Also, mental health funding is not distributed in ways that promote a focus on client recovery outcomes, innovation or cost-effective approaches.

Addressing human resource needs is an immediate concern that requires a province-wide response involving the education sector and federal workforce development agencies. The need to focus on mental health promotion and mental illness prevention as well as address stigma relating to mental disorders requires the Ministry to be more proactive and supportive of public education that can improve the awareness of unmet needs and reduce the effects of stigma.

The Ministry has the province-wide vantage point across all regions and must ensure that oversight and accountability mechanisms are in place. There is need for a provincial mental health information system to monitor access and participation and ensure that outcomes are being met. Furthermore, development of system and service standards are foundation elements that must be put in place if we are to have a mental health system that truly focuses on needs of consumers and their families.

These roles for the Ministry are demanding and require proactive leadership, adequate internal staffing, fair and transparent processes to ensure that mental health services are a priority truly reflecting the degree of burden mental illness places on overall health status of the Ontario population. Concern for the welfare of people who have mental illness is inadequate to motivate change. Everyone must understand how policy and funding decisions move the province closer to realizing mental health reform expectations. Without clear and constant accountability, mental health will continue to reflect an inadequate and forsaken component of Ontario's health care system.

The day-to-day management roles for a community-based system of mental health care and who best to assume this role must be considered in light of all the demands of the Ministry. Effective mental health system accountability and management requires the ability to identify strong and weak links, well- and under-performing partners and implementation of an incentive-based approach for service quality improvements. At this time, the Ministry has neither the staff nor expertise nor the ability to act swiftly when there is need for corrective action. The level of decision-making regarding delivery of care must be as close to the community as possible. Integrated mental health agencies require global budgets so as to deliver comprehensive care that is highly flexible and tailored to individual need. Regional managers require the ability to work with system partners addressing performance and outcome issues and planning system changes and developments to ensure future capacity and response to changing needs.

The final recommendations of the Northeast Mental Health Implementation Task Force (see Table I) require immediate and careful consideration by the Ministry of Health and Long-Term care. There are recommendations that may be implemented without undue expense and these should move ahead as soon as possible. There are also important opportunities to pilot and test significant system innovations. Implementation of the integrated mental health agencies across the region is the first priority as this will proactively address the outstanding needs of people with mental illness and their families.

The people of Northeastern Ontario are ready for action.

Table I		
Final Recommendations of the Northeast Mental Health Implementation Task Force		
Recommendation	Type	Section
SECTION 2: VALUES AND VISION		
The MOHLTC should formally adopt a recovery-oriented vision for Ontario's mental health system. A policy statement like that issued by the State of Connecticut (see Section 1 Appendix 1.1) should be announced by the Minister in Spring, 2003.	Policy Implications	1 2
The MOHLTC North Region should take the following steps to begin implementation of a recovery orientation among all present and future mental health service providers: a) that an education/training conference be held for all system stakeholders in Spring, 2003, to introduce the values and concepts of a recovery-oriented system of care; b) that existing service agreements be revised such that all boards responsible for the delivery of mental health services (including hospitals) are required to revise program objectives and deliverables to be in keeping with a recovery-oriented approach to mental health care.	Service and Supports	2
The MOHLTC North Region should assign the task of developing a training program for all stakeholders in the Northeast mental health system to the Regional Transition Team (see Sections 16 & 17) as a priority task. This training program should have the goal of reaching all levels of staff working in the system so that they understand the recovery vision and its implications within service categories. The program may involve selection and training methods from other jurisdictions and must be designed to improve knowledge, attitudes and skills necessary to conduct the range of services in the continuum of care. The proposal should be ready no later than July of 2003 for funding consideration by the MOHLTC.	System Implementation	2 16 17
SECTION 3: OVERVIEW OF MAIN SYSTEM COMPONENTS		
The Northeast mental health system must be defined by comprehensive linkages between the system partners. Service protocols must be developed and defined for all levels of the system. The integrated agencies are expected to have agreements with all local community hospitals with regards to provision of crisis services. These agencies will also have agreements with the Schedule 1 hospitals to which they relate in their district(s) and the Northeast Mental Health Centre. Community and Schedule 1 hospitals also require such agreements, as do Schedule 1 hospitals with the Northeast Mental Health Centre. (See Hospital Role Chapter for more details). The MOHLTC must mandate development of these service protocols and agreements as part of the system change process.	System Implementation	3 12 16 17
The MOHLTC must review and consider the need for legislative changes with regards to mental health service delivery. The current Mental Health Act is silent as to the role for community mental health programs. In order for the integrated mental health agency to fulfil its role in terms of being responsible for managing the "front and back doors" of the mental health system and ensuring that people with mental illness are supported as much as possible at the community level, this role needs to be formally enshrined and likewise the role of hospitals restated.	Policy Implications Legislative Considerations	3 4

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SECTION 4: SERVICE DELIVERY BY THE INTERATED AGENCY		
<p>The MOHLTC, through the North Region Office, immediately fund a regional project to research and define a strengths-based assessment and triage process to be based on best practices for use in all districts by mental health service providers. This project requires an advisory committee made up of a cross section of representatives including people with mental illness, family members, front-line community mental health and Schedule 1 hospital staff with relevant clinical expertise. The purpose of the project is to identify and recommend a set of instruments and screening tools that should be adopted for use as part of the assessment process. The goal is to ensure that the level of care a person receives is well matched to their needs and personal goals as expressed in his/her care plan.</p>	Services and Supports	4
<p>Once this assessment process is defined, the MOHLTC North Region must direct all mental health services to:</p> <p>a) use the defined process for all people seeking service. Where programs are still outside of the integrated mental health agency, local processes must be defined and operationalized to ensure individuals no longer receive multiple assessments and that one care plan is developed for the individual over the multiple programs.</p> <p>b) existing care plans for people currently receiving services should be reviewed and updated to ensure people are receiving support appropriate to their identified level of need and personal goals and based on a strengths-based approach.</p>	Services and Supports	4
<p>The MOHLTC should immediately review those specific clinical interventions that have been demonstrated as evidence-based practices. Specifically, the US Center for Mental Health Services, under contract to Dartmouth Psychiatric Center, is creating toolkits to guide agency implementation of these practices in the following areas: supported employment, assertive community treatment, psychopharmacology, integrated treatment for individuals with concurrent disorders, family psychoeducation and self-management of symptoms and dialectical behaviour therapy (DBT). The NEMHITF requests that appropriate training opportunities for implementation of these practices within the reformed system. The MOHLTC must move quickly to endorse these and other emerging best practices and mandate their implementation throughout Ontario.</p>	Policy Implications	4
<p>The MOHLTC North Region should commission an immediate review of all crisis programs in the Northeast. Using the template for integrated agency development, specific proposals should be developed to upgrade crisis services in the immediate future to full 24/7 capacity, outreach to all community hospitals complete with service agreements, working linkages with other support services so that people are properly directed to longer-term supports if required.</p>	Services and Supports	4 Community CAP Study
<p>With the establishment of the integrated mental health agencies, all crisis services should be divested from hospitals to the integrated agencies.</p>	Services and Supports	4
<p>Given that the first-line team represents a new capacity in the Northeast system, the MOHLTC North</p>	Services and	4

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Region should encourage providers to become familiar with shared care models including the pilot project underway by NBPH and the program in Hamilton. This capacity must be established as a core program in the integrated mental health agencies.	Supports	
As part of the District Transition Team process (see Section 16), discussions must be initiated with front-line staff to address the integration of service and support functions into the Intensive Team. Reformulation of existing staff positions into the team is the starting point with new positions being incorporated within the teams as resources become available.	Services and Supports	4 16
To support hiring of psychiatrists and physicians in the integrated mental health agencies, the MOHLTC North Region should provide leadership on the issue of alternate payment mechanisms to make this a reality.	System Implementation	4
The MOHLTC North Region should, with the data collected in the community mental health program audits and the Muskoka-Parry Sound Community Mental Health Services report, examine the issue of appropriate levels of staffing for managerial and administrative functions and immediately pursue funding opportunities to right size the number of these positions in the system. Implementation of these positions should be within the perspective that they will transition to the integrated agencies (where these are still to be established) and provide the necessary capacity for these new organizations to deal with changes resulting from mental health reform and establishing sound service delivery practices that are outcome and recovery focused.	Services and Supports	4
Following the adoption of the accountability framework for mental health services, the MOHLTC should immediately pursue the implications that focusing on service outcomes has on its funding and budget requirements and processes for all mental health services. The goal must be to refocus on service delivery outcomes for all partners in the mental health system and move away from being too prescriptive on budgets and staff inputs.	Policy Implications	4 14
SECTION 5: CONSUMER INITIATIVES AND SUPPORTS		
The NEMHITF recommends that the range and number of roles people with mental illness can have in the mental health system be recognized and supported in equitable terms - in governance, in remuneration for paid positions in the mental health work force, in adequate funding for self-directed initiatives or businesses. This recognition is integral to operationalizing the recovery-based philosophy and truly respecting the individual at the centre of the mental health system.	Policy Implications Services and Supports	4 5 6 16
Consumer initiatives are an essential part of the full continuum of mental health services. CSIs need to be more accessible to people who have mental illness. Resources for enhancements of existing projects already funded by the MOHLTC and possibly funding for other initiatives are required. The MOHLTC shall allocate a minimum of 1% on top of the existing mental health budget to consumer-based district and regional initiatives to support growth of the CSIs within the mental health system, thereby providing increased opportunities for peer support and other activities which utilize and enhance the skills and	Policy Implications	5

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capacities of individuals with lived experience. The 1% should be phased in over a 2-year period.		
After the initial phase-in of 1%, an annual increase of .5% per year of the mental health base budget will be allocated to consumer-based district and regional programs, with yearly evaluations.	Policy Implications	5
The long-term target is for the North Region Mental Health Board and the integrated mental health agencies to allocate a minimum of 5% of the mental health base-budget to consumer-based district and regional programs over a time frame not to exceed eight years.	System Implementation Services and Supports	5
<p>Pending the creation of the integrated agencies, Northeast Ontario Network (NEON) will develop an accountability framework and a process for defining priorities and allocating the new money for consumer initiatives according to the needs within each district.</p> <p>Priority areas for targeting new money should include:</p> <ul style="list-style-type: none"> ✓ leadership and administration training; ✓ social and recreational opportunities and physical activity programs; ✓ discretionary funding to implement individualized rehabilitation plans; ✓ consumer employment initiatives in each district; ✓ peer support that reflects ethnocultural, Francophone and First Nations communities; and ✓ consumer training in facilitation and evaluation skills. 	System Implementation Services and Supports	5
<p>Participation of individuals with mental illness and family members of the governance structures of the integrated agencies and the North Region Mental Health Board will be fostered by:</p> <ol style="list-style-type: none"> a) provision of honoraria and expenses as appropriate; b) forging of partnerships with NEON and local CSIs to provide required training for board and committee members and for the provision of mentors and mentoring processes. 	System Implementation	5
The integrated mental health agencies will offer peer support services to individuals with mental illness and family members that reflect ethnocultural, Francophone and First Nations communities, and provide opportunities for their participation in the development, implementation and evaluation of mental health programs.	Services and Supports	5
The MOHLTC and Ministry of Community, Family and Children's Services (MCFCS) will advocate for payment rates of the ODSP to rise to meet the levels identified as the Low Income Cutoffs by Statistics Canada.	Policy Implications	5
Recognizing that mental health outcomes are positively related to income levels, the MOHLTC and MCFCS will take action on ODSP issues currently before the MCFCS. These include increasing ODSP rates so that the amount of income support provided will be indexed to the cost of living and adjusted every April 1.	Policy Implications	5

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<p>The MCFCS must simplify the cumbersome ODSP application process by:</p> <ul style="list-style-type: none"> a) providing in-person staff assistance to complete the forms and provide up-to-date information b) providing a “fast track” mechanism to allow individuals to quickly re-enter the income support system without a full application process (recognizing the episodic nature of mental illness that may force working consumers to become disabled again); and c) improving the communication linkages between Ontario Works, ODSP and the Canada Pension Plan. 	Policy Implications	5
<p>All income support payments will be made directly to individual consumers except in instances where short-term assignment of authority has been granted until the consumer is able to resume full control over their personal affairs and responsibilities.</p> <ul style="list-style-type: none"> - as the long-term goal of moving from custodial toward supported housing occurs, income support payments will be provided directly to consumers - supports will be provided to consumers through education or voluntary trusteeship in order to ensure successful financial management <p>In the interim/short-term, the PNA should be increased to \$160.</p>	Policy Implications	5
<p>The MCFCS should increase job support assistance to those on ODSP who are able and willing to work by:</p> <ul style="list-style-type: none"> - ensuring all local income maintenance support offices have a lead employment contact to liaise with consumers seeking employment and mental health employment support workers to address issues/concerns - letters of suspension without prior discussion/consultation should be reduced or eliminated; - eliminating financial disincentives (i.e., loss of income support) by increasing the amount of allowable earning without deduction or loss of income supports and drug benefits need to be addressed to support transition to employment; - eliminating monthly reporting of earnings and instituting annual or semi-annual reporting to reduce consumer stress and allow averaging of irregular earnings would result in fewer opportunities for system errors and income interruption - ensuring payment for training programs; and - funding employment programs based on positive employment outcomes. 	Policy Implications	5
SECTION 6: FAMILY SUPPORTS		
<p>Professional attention is still devoted largely to treating the consumer. A large number of family members of people with severe mental illness, will be, by necessity, an integral part of their loved one’s treatment and care. As the system moves to a community-focused concept of mental health, professionals need to embrace a strengths perspective and see families as essential partners in assisting people with recovery.</p>	Services and Supports	6

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<p>Families can be valued collaborators when:</p> <ul style="list-style-type: none"> a) all health care professionals recognize and support the role the family plays in treatment, rehabilitation and recovery b) family members, through education, understand the illness and act as the eyes of the professionals. Over 60% of people with severe mental illness live at home or under the direct care of their family (Seeman, 1988). Thus living supports, medication, lifestyle changes and crisis situations can be monitored c) trained family members assist in diffusing stressful situations and provide a centre of stability for the person with mental illness. 		
<p>Mental illnesses are complex disorders. In order to be effective advocates, to provide ongoing support for their loved ones, and to maintain their mental health, families require:</p> <ul style="list-style-type: none"> a) family-focused information and education programs on the mental illness of their loved one b) information on how to navigate the mental health system, i.e., a resource directory; access to staff whose role is to explain the system. c) education courses similar to the National Association for the Mentally Ill (NAMI) "Family to Family" course and the Schizophrenia Society's High School Education Program d) commitment to a statement of "Principles for Meaningful Involvement of Families" e) education developed by, and provided to, families through family organizations like the Ontario Schizophrenia Society and Depression and Manic Depression Association - financed by health care dollars. Family groups should also be invited to take a leadership role to assist mental health services to develop family support programs within the continuum of care f) education on mental health related legislation: <ul style="list-style-type: none"> - Mental Health Act - Health Care Consent Act - Substitute Decisions Act g) education and support with respect to estate planning and advance care directives. 	Supports and Services	6
<p>Advocacy is empowering. Development of a family advocacy organization, a Canadian version of the National Alliance of the Mentally Ill (NAMI) or at a minimum a provincial coalition of the mental illness family groups is vital in order for advocacy to be effective. This organization, funded from health care</p>	System Implementation	6

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dollars, would provide families an opportunity to speak with one voice, and work together on common goals.		
In each of the five districts/district clusters in the Northeast, adequate funding must be allocated for enhancement of family initiatives that will cover the rural and remote geography of the region. The opportunity for sharing administration and physical space within the integrated lead agencies must be considered. Groups will retain autonomy over program planning, objectives and delivery.	Services and Supports	6
Respite care services for primary caregivers of individuals with mental illness must be developed. The program should be tailored to the individual family requirements; the ideal model would enable someone who is ill to remain in their own home while the family member is away. Skills of a personal care aid or a qualified mental health worker should be matched to the needs of the care receiver. Respite services could range from a few hours a day, week or month to a more focused period of days or weeks, as required. Other types of innovative respite options should also be explored should resources prove limiting (e.g., there might be respite beds available within a community-based crisis program.)	Services and Supports	6
All teams within the integrated agencies will work with individuals who have mental illness and their families. Families are entitled to supports even if the person with severe mental illness refuses help at that time or does not wish to have families directly involved in their care. These supports, as a minimum, should include: education regarding mental illness, practical help, emotional support, linking and coordination services, ongoing follow-up as appropriate, contact person within the agency; and participation in the care planning with person's permission. All existing and the emerging integrated agencies must extend their services to include family support.	Policy Implications Services and Supports System Implementation	6
Family representation and input to planning, implementation, delivery, monitoring and evaluation of services at the program and system level are essential. a) every mental health agency should have designated seats on their Boards and Committees for family members b) standards must be developed which articulate the role of the family in various situations, e.g., hospital stays, outpatient/community programs, community support, crisis, etc. c) evaluation of mental health programs, services and system should include indicators to measure family involvement and outcomes d) family mentor positions need to be funded and implemented in all mental health organizations in the Northeast mental health system.	Policy Implications System Implementation Service and Supports	6
The MOHLTC should expand mental health policy provisions concerning families to include:	Policy Implications	6

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Recommendation	Type	Section
a) mandating family psychoeducation by all Ministry funded mental health programs; b) developing provincial standards for services addressing family needs and outcomes; and c) developing policy and provide funding to support family mentor positions in all mental health programs.		
SECTION 7: EMPLOYMENT AND EDUCATION		
That the MOHLTC develop the standards and guidelines for employment supports that were promised in the <i>Making It Work</i> policy framework. Once this policy work has been achieved, the MOHLTC should submit a request through the annual government budget process on behalf of all regions to infuse permanent operating funding to develop appropriate educational and employment support capacity within local systems of care.	Policy Implications	7
That the MOHLTC provide immediate and equitable levels of funding to consumer initiatives throughout the province with an emphasis on innovative and peer-oriented models of educational and employment supports.	Policy Implications System Implementation	7 5
That the MOHLTC formally embrace the recovery approach for mental health service development.	Policy Implications	7 1 2
That the MOHLTC promote reform and advocate for evidence-based practice in rehabilitation and recovery services.	Policy Implications	7 4 14
That the MOHLTC fund more best practices demonstration and research projects to test pre-employment, employment and supported education initiatives in urban, rural and remote settings.	Policy Implications Services and Supports	7
That the MOHLTC liaise with the Ministry of Community, Family and Children's Services regarding proactive reforms of the ODSP and Drug Benefit programs so as to eliminate barriers that, in effect, punish individuals who wish to work. Consideration must be given to revamping income support programs to be fully supportive of people who may cycle in and out of formal employment because of mental illness.	Policy Implications	7
That education, pre-employment and employment data elements be designed and included in the development of the province-wide mental health information system. These indicators must go beyond those listed in the <i>Making It Work</i> framework and include quality of life variables that reflect the individual's and family's perspectives.	Policy Implications System Implementation	7 13 14
That the MOHLTC assume its leadership role in knowledge dissemination in the area of supported education and employment through ongoing training and education efforts aimed at all partners in the	System Implementation	7

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Recommendation	Type	Section
Northeast mental health system and other regional systems of care. This may include ensuring regular communication on ongoing research projects funded by the MOHLTC, annual conferences, web-based telecasts with experts and so forth.		
That the MOHLTC North Region distribute financial and human resources with a priority to supported education, rehabilitation and pre-employment and employment supports in the immediate future to ensure these capacities are developed within the local continuums of care. Further, that within all funding allocations, the MOHLTC North Region ensures that one employment/rehabilitation specialist is hired in each of the five districts/district clusters to provide local leadership and direction in the development and integration of these services in the local service continuums.	Services and Supports System Implementation	7
That the MOHLTC North Region ensure recovery principles and psychosocial practices are incorporated into all mental health services in the Northeast including: a) integrating recovery concepts into clinical treatment b) support rehabilitation supports including those related to education and employment as primary interventions at the onset of illness c) assess individual readiness to begin rehabilitation and monitor changing needs over time as a function of the integrated agency d) ensure that all intensive/Act teams have at least one vocational specialist on staff e) ensure that integrated agencies take steps to ensure that language, age and culture will not be barriers to receiving needed rehabilitation services.	System Implementation Supports and Services	7 2 4
That the MOHLTC North Region establish accountability within the Northeast region by ensuring that all mental health services: a) seek accreditation through appropriate organizations and adopt standards for practice; b) implement standardized data collection utilizing outcome measures; and c) implement consumer satisfaction surveys.	System Implementation Services and Supports Policy Implications	7
That integrated agencies sustain access to supported education within its district by: a) ensuring individual access to supported education within three months of referral b) ensuring that coordination exists among mental health service providers within the districts and across the region with regards to supported education c) participate in a regional advisory committee to work in partnership with relevant partners like post secondary institutions, boards of education, vocational rehabilitation services and appropriate provincial and federal ministries d) participate in training and education activities within local colleges and universities regarding the needs of people with mental illness.	Services and Supports	7
That integrated agencies sustain access to pre-employment and employment services within its district by:	System Implementation	7

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<ul style="list-style-type: none"> a) ensuring that individuals access pre-employment services within three months of referral b) ensure coordination between the agency and community-based pre-employment and employment services c) participate in a regional advisory committee to work in partnership with relevant partners like post secondary institutions, boards of education, vocational rehabilitation services and appropriate provincial and federal ministries to address pre-employment issues d) form local committees and advisory groups to create and foster linkages with the business community and relevant non-profit agencies for developing a range of work experiences, work shadows, volunteer options, mentoring to consumer businesses and so forth. 	Services and Supports	
<p>It is recommended that:</p> <ul style="list-style-type: none"> a) ODSP Income Supports and ODSP Employment Supports coordinate their efforts to ensure a cooperative approach to both providing incentives and supports to persons with disabilities who wish to return to competitive employment b) ODSP ESP review the time-limits they have set on their goods and services in an effort to increase the opportunities for successful integration into paid employment for persons with the most severe disabilities c) The rules around subsidized housing be relaxed for persons with disabilities wishing to earn an income. 	Policy Implications	7
<p>CPP Disabilities, ODSP Income Supports and ODSP ESP develop an active communication/marketing strategy that is more consumer-friendly, that reduces fear among individuals relative to additional earned income and that promotes incentives rather than the disincentives to returning to and maintaining paid work.</p>	Policy Implications	7
SECTION 8: HOUSING		
<p>The MOHLTC should update its ten-year benchmark (2002/2003) for housing spaces including a review of the assumptions used in developing the current benchmark.</p>	Policy Implications	8
<p>The MOHLTC should establish an information system that will capture, on an annual basis, the actual housing needs of people with mental illness as well as an inventory of the housing and supports capacity (including new developments) and demands/waiting lists. This inventory will be used to support planning and resource allocation across the region including the local integrated agencies.</p>	Policy Implications System Implementation	8 13
<p>The Ministry of Community, Families and Children’s Services review the ODSP and OW so that:</p> <ul style="list-style-type: none"> a) The ODSP/OW shelter allowance component be increased to allow a person to rent an existing housing unit (includes rent and essential utilities). b) The shelter allowance portion of the income maintenance program be indexed to the market rents 	Policy Implications	8

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<p>and housing costs in different cities and will, therefore, vary from city to city. Note: These measures would remove the need to deliver administratively complex and expensive programs, such as rent supplement, to essentially address an income problem. The rent supplement program provides a supplement to a landlord so it is tied to a unit of housing, not the individual in need.</p> <p>c) That ODSP policies and procedures that restrict access to this income support program for people who have mental health problems and particularly for those who are homeless, be revised. The requirements for medical information are cumbersome and need to be reexamined.</p> <p>d) That a procedure be found to address the problem of people losing their housing due to loss of income support program when a person leaves their permanent housing for a specific reason (e.g., hospitalization, incarceration, abuse, other treatment, etc.)</p>		
<p>As part of a multi-year plan, the funding and business model for mental health housing for the Northeast should take into account the immediate need for housing for inpatients at the NBPH who are awaiting transfer to the community (including planned bed reductions). (Note: The HSRC estimated that a bed closure affects 4-8 patients per bed; i.e., the number of persons with mental illness who regularly use these mental health beds.)</p> <p>Refer to Table 8.2: Summary of Mental Health Housing Spaces Required in the Northeast.</p>	Services and Supports System Implementation	8
<p>The MOHLTC's Five Point Development Strategy for new mental health housing includes community development, head lease/rent supplements, effective use of current supportive housing stock, purchase/renovation of current stock, and residential care, where appropriate. This strategy should be expanded into a funding and business model for the Northeast that includes the full participation of both the private and public sectors in the development of new housing including the building of new stock in areas with low vacancy rates (e.g., less than 3%) through:</p> <p>a) Capital and incentives provided by the government for non-profit and other partnerships as well as for families (e.g., tax rebates or exemptions, incentives to rebuild/renovate the family home to accommodate the needs of the person with severe mental illness, etc).</p> <p>b) Private builder providing stock with units available to MOHLTC funded community-based mental health agency via a head lease arrangement to pay market rent.</p>	Policy Implications	8
<p>Additional independent living housing arrangements must be developed across the Northeast to bring the percentage of independent living housing arrangements closer to the preferred 70%. This includes supported mental health housing spaces (i.e., long-term housing with delinked support) and supportive housing with a variety of housing options but with an emphasis on supportive apartments. Refer to Table 8.2 Summary of Mental Health Housing Spaces Required in the Northeast.</p>	System Implementation Services and Supports	8
<p>As more independent living spaces become available, the number of residential care spaces (HSC and Domiciliary Hostels) should be reduced to move closer to the preferred 30% of the total of independent and residential care housing spaces.</p>	Policy Implications System Implementation	8

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The MOHLTC North Region establish a Northeast Mental Health Housing Workgroup to undertake a five-year review of best practices and research as well as to establish an ongoing evaluation of current and proposed housing and supports. The Northeast approach will reflect a flexible approach that is responsive to changes and the ever-changing needs of people and community conditions. The routine evaluation will utilize an accountability framework that includes the tracking of funds and measuring of outcomes with respect to housing and supports along the continuum of care.	System Implementation	8
A special housing model in the Northeast will offer a range of housing options to residents. Due to some of the challenges in Northern rural areas (e.g., lack of critical mass, staffing and transportation issues), respite and crisis beds should be co-located with the high support housing to meet local needs.	Services and Supports System Implementation	8
The development of the proposed HPSN (HSC and Domiciliary Hostels) program will be formally recognized within the reformed Northeast regional mental health system. HPSN will be affiliated with the integrated agency in their area and individual residents will have access to the full range of supports and service available through the integrated agency. Standards for HPSN will be in line with the recovery approach. Over time, the administration for these homes could be transferred to the Northeast Mental Health Centre.	System Implementation Policy Implications	8
Each person should have access to individual treatment and supports if needed (ACT teams, case management, community support workers, psychosocial rehabilitation, employment/day activity, CCAC home care, etc.). It is the responsibility of the integrated mental health agency to be the access point for supportive housing to support consumer choice, improve efficiency, reduce barriers, etc. The following are the functions of the one stop access point: a) hold an accessible, up-to-date inventory of housing resources dedicated for people with SMI. b) link with the municipal housing registries as well as with services that help people find housing and with other supportive housing groups. c) through a collaborative approach involving consumers and existing engaged providers, help determine appropriate housing and supports using standardized assessment and risk management tools which match needs with the housing, treatment and supports continuum options. d) follow through to ensure that a person gets into housing of choice. e) hold the waiting list based upon highest needs rather than chronological “first come, first served” as well as other waiting lists based on subsequent assessments to facilitate movement and allow people to move on to more appropriate housing options as their needs change. Coordination with other waiting lists (such as those for municipal social housing which are chronological) will be needed. f) provide a process to resolve cases in which there is a disagreement as to the admission of a resident to a facility (this will include the reference to conflict resolution clauses in service agreements with housing providers and to system conflict resolution mechanisms.)	Services and Supports	8

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Recommendation	Type	Section
That each integrated mental health agency, through its housing team, develop direct linkages with private landlords to advocate for more accessible housing, develop supportive strategies so more people with mental illness are welcomed and foster creative community approaches to housing.	Services and Supports	8
That mechanisms for linkages to support services and crisis management be developed for landlords and others.	Services and Supports	8
People with severe mental illness have access to a wide range of professional home care and home support services delivered in a flexible and appropriate manner as identified by the individual whatever their living arrangements.	Policy Implications System Implementation	8
The eligibility criteria for CCACs should include people with a primary or secondary diagnoses of psychiatric illnesses.	System Implementation	8
That the need for reduced caseloads for home support services due to the complexity of needs of individuals be recognized and funded accordingly.	Policy Implications	8
Ongoing education and training in caregiving issues related to those with severe mental illness should be available to professional and paraprofessional staff as well as volunteers. This training would place emphasis on the principles of psychosocial rehabilitation and the recovery model and address issues related to safety, stigma, crisis, etc.	System Implementation Services and Supports	8
That additional funding be provided for home support services to increase access for people with severe mental illness.	Policy Implications	8
That home support services formalize and expand collaborative inter-agency approaches to planning and delivering of services, including protocol development and shared care planning.	System Implementation Services and Supports	8
That the MOHLTC North Region give immediate consideration to the proposal for housing by the James Bay Community Mental Health Program given the high level of need, the remote location of communities on the coast and distance from specialty treatment beds. This project could serve as a unique pilot for a hybrid housing approach that serves multiple functions including crisis, respite and transitional spaces.	System Implementation	8
SECTION 9: FORENSIC MENTAL HEALTH SERVICES		
That a human service and justice coordinating committee exists in each of the five locations in which an integrated mental health agency is created and that the integrated mental health agencies in the Northeast become the primary support structure for the coordinating committees.	System Implementation	9
Key to the reform strategy envisioned for the Northeast is the participation of persons with mental illness in determining the appropriate supports and services to meet client needs, as such they must participate as active members of the coordinating committees.		

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<p>These committees, however, have functioned with limited support by ministries and have relied primarily on the goodwill of the individual committee members to sustain their work. The integrated mental health agencies are uniquely positioned such that they can provide the necessary support and structure to these coordinating committees. Until such time as the integrated mental health agencies are established, the District Health Council together with the MOHLTC regional mental health consultant should provide this support.</p> <p>A fundamental principle inherent in the design of the coordinating committee is that it would provide local solutions to local problems. This will be a group of service providers and ministry stakeholders who, at the outset, will develop an understanding of local needs and work on these. It is not only an understanding of local services but also local hard to service clients. The awareness and understanding of the needs of that particular group, who are predominant in the justice system, will make proactive planning easier to implement and more effective. In communities where coordinating committees do not exist, the closest coordinating committee will ensure involvement and participation through membership and the creation of sub-committees.</p>		
<p>Because the emerging issues identified cross jurisdictional boundaries and impact on forensic psychiatric services in the region it is recommended that coordinating committees working with key regional and local support e.g. DHC and MOHLTC regional office to assess the impact of these issues locally. Human Services and Justice Coordinating Committees are considered the primary vehicle to facilitate cross section service coordination in response to client needs, and address such issues access to, duplication of services and new issues that impact on service availability. In addition, coordinating committees are expected to lead a multi system design and planning effort to improve service system linkages and integration to protect public safety and provide a continuum of care to common forensic clients.</p>	System Implementation	9
<p>The five integrated mental health agencies work with the criminal justice system to ensure equitable access for all individuals to community-based mental health services and supports in the Northeast, which includes cross-sector planning and the negotiation of protocols and service agreements.</p> <p>In addition to a wider interest in access to mental health services, the justice sector has a direct interest in the following areas:</p> <ul style="list-style-type: none"> • Crisis response and police/mental health linkages • Diversion processes and linkages (both police and crown) • Option for streamlining court administration processes • Treatment/case management programs (community, jail, hospitals) 	Services and Supports	9

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Recommendation	Type	Section
<ul style="list-style-type: none"> • Implications of hospital and social services restructuring • Access to services in rural versus urban areas • Special needs population • Broader social service sector involvement 		
<p>The integrated mental health agencies support the addition of new resources in the following areas: police diversion and mental health crisis response with the police; case management resources to augment the mental health court workers; case management street workers tied to the police and housing programs; mental health discharge planners working with discharge planners in the jails and correctional centres.</p> <p>These resources will provide support to core services provided by ministries. A number of core services have implications for shared treatment and placement planning arrangements between service sectors (i.e. shared planning and information exchange processes with respect to common clients; multi-ministry case management team for clients involved in more than one system and core services clinical teams located in provincial correctional facilities. Core service elements include the regional forensic Services, other community and mental health programs, ACT Teams and CTO coordinators and other strategies to minimize police involvement with mentally ill and developmentally disabled persons. For the courts core services include, court based case management and coordination. For Corrections core services include, general treatment, rehabilitation discharge planning and case coordination to release offenders back into the community, and case coordination for probation and parole.</p> <p>It is highly desirable that the costs for these new resources be borne by all partner Ministries, but it is also recognized that the time frame in which such partnership agreements could be arrived at may be very lengthy.</p>	<p>Services and Supports Policy Implications</p>	9
<p>That a coordinating committee be tasked with exploring the feasibility of a 10-12 bed “transition house” for hard to treat mentally ill and developmentally disabled person.</p> <p>These difficult to serve individuals who often present with somewhat higher risk levels experience difficulties in accessing and remaining linked to existing services. They are often homeless, do not fit into any of the community housing programs, and require case management and a higher, more secure setting than what is currently available in the community. A pilot multi-ministry initiative could be instructive for other parts of the province. Such an initiative could be in the form of a hospital community agency/ landlord agreement, where the landlord provides the housing unit(s) and the clinical staffs are provided by the hospital and community agencies.</p>	<p>System Implementation</p>	9
<p>The integrated mental health agencies direct and support coordinating committees to develop protocols</p>	<p>System</p>	9

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<p>with the police to:</p> <ul style="list-style-type: none"> • Ensure that crisis interventions are linked to the agency crisis response teams, to maximize opportunities of appropriate linkages to community mental health services and support as well as connect persons with mental illness to services for longer term follow up. • Develop protocols between the police, community service providers and schedule 1 hospitals to reduce the time police are required to wait at a hospital with a mentally ill person. <p>Frequently police are requested to intervene in a crisis situation involving the mentally ill. When there is a lack of community alternatives, the police may be forced to take a person to a hospital or alternatively arrest them on a minor offence and have them placed in jail. The Sudbury Coordinating Committee has developed a protocol between the police and the Schedule 1 hospital to reduce the time that police are required to wait at the hospital with a mentally ill person. These protocols have been developed in a number of cities and have proven to be effective in ensuring prompt attention for individuals in crisis who are accompanied by police officers to a hospital.</p> <p>In addition, police need to be linked to crisis support workers as partners in the development of a plan where effective diversion to community supports provides an alternative to arrest for a minor offence. Police diversion is the most effective point for diversion of a mentally ill person as it ensures minimal contact with the criminal justice system and avoids the additional stigma attached to individuals who become identified as “forensic” clients.</p>	<p>Implementation Services and Supports</p>	
<p>Screening for fitness and routine fitness assessments should be conducted at court or at fitness clinics established in correctional institutions.</p> <p>Studies indicate that two thirds of individuals that are assessed for fitness to stand trial are found fit. In the Northeast mental health court workers have been trained to screen for fitness, and a fitness clinic has been established in the North Bay Jail and one proposed to be established at the remand facility of the Northern Treatment Center in Sault Ste. Marie. This significantly reduces the number of individuals who need to be directed to a forensic bed at the North Bay Psychiatric Hospital for fitness assessment. As a matter of practice, routine fitness assessments should be conducted either at court or in jail, reserving forensic beds for only the most complex fitness assessments.</p> <p>In Sudbury a mental health court has been established modeled on 102 Court at Old City Hall in Toronto. To date a total of 99 mentally disordered accused have been assessed and diverted from the criminal</p>	<p>System Implementation</p>	<p>9</p>

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justice system in the eight months period of its operation. Currently the Sudbury Coordinating Committee is considering combining the court with a drug court, given the number of mentally disordered offenders with a co-morbidity.		
The Sudbury Coordinating Committee should continue to explore the feasibility of a combined mental health and drug court.	System Implementation	9
Mental health professionals must be trained to accept and treat minor offenders in the community including mentally ill individuals at the end of their sentence and those under probation supervision.	Services and Supports	9
Forensic beds should be reserved for those individuals who have been found NCR and are violent, dangerous or their criminal acts require that they be in a secure setting; and for complex fitness assessments or court ordered treatment.	Services and Supports	9
Some mentally ill accused that are before the courts should have access to Schedule 1 beds, if they are in need of treatment and are suitable for admission. There is a role for Schedule 1 hospitals to play in the process of management and treatment of mentally ill persons who come in conflict with the law. The majority of mentally ill persons who commit offenses, particularly minor nuisance offenses come from the general psychiatric stream and have the same needs as other mentally ill persons. The fact that they are now defined as mentally disordered or forensic is more often a matter of labeling.	Services and Supports System Implementation	9
That the Correctional treatment services planned for the Near North be factored into the resource calculation of available services for Northeastern Ontario, and that the service be a partnership between MPSS and the Northeast Mental Health Centre. Correctional Services is planning to build a treatment facility (Near North Treatment Centre) on the grounds of the existing North Bay Psychiatric Hospital. This jail will include 50 beds for mentally disordered offenders with the service provider being the Northeast Mental Health Centre. It will be structured similar to the St Lawrence Valley Centre in Brockville.	Policy Implications	9
The integrated mental health agencies must ensure that individuals discharged from a forensic program or a correctional institution are linked to the appropriate level of community supports and services consistent with their needs, which includes access to generic mental health services.	Services and Supports System Implementation	9
The information system developed for the Northeast includes a database that is accessible and available to the criminal justice system to ensure continuity of care for the seriously mentally ill.	System Implementation	9 13
SECTION 10: SENIORS' MENTAL HEALTH		
Community Support Services – Additional community support services are required to help individuals	Services and	10

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age in place. These additional resources will range from Meals on Wheels programs to personal support services. The Long-Term Care Annual District Service Plans provide documentation about these services including unmet needs and gaps	Supports	
Crisis Support – Twenty-four hour crisis support services must be available in local communities. Existing crisis support services should be expanded to include people over 65 years of age. Mobile crisis support teams need consideration, particularly to meet the needs of older adults with reduced mobility.	Services and Supports	10
Counselling/Psychotherapy – This service for seniors should be available as another of the First Line services. Early intervention is essential.	Services and Supports	10
CCACs need a clear mandate to provide service to the psychogeriatric population.	Policy Implications	10
CCAC eligibility criteria should include those with primary and/or secondary diagnoses of mental illness(es). CCACs must develop service protocols with mental health service providers at all levels.	Policy Implications System Implementation Supports and Services	10
Community Mental Health Programs – The mandates of these programs must be expanded. Community support workers/case managers must be conversant in geriatrics and mental health in order to support a care pathway for a client with multiple needs. As noted in the above recommendation, there is a need for the melding of expertise from the fields of mental health and geriatrics. Community Mental Health Programs including ACT teams must develop service protocols with CCACs and addiction services.	Services and Supports System Implementation	10
The integrated mental health agency must have a clear mandate and the resources to establish specialized psychogeriatric teams that will work alongside the ACT team.	Services and Supports	10
Psychogeriatric Teams/Seniors' Mental Health Programs including the Regional Nurse positions – The MOHLTC should immediately determine the current human resources in psychogeriatric programs in the region followed by the adoption and application of the Clarke Institute Consulting Group benchmarks for human resources for these services in order to achieve equitable staffing and service levels across the Northeast Region. The Regional Nurse positions of the SMHP of the NBPH should be supported by a full-time team leader position.	System Implementation Policy Implications	10
Psychogeriatric Consulting Resources – Due to the size of the Northeast Region, the MOHLTC should increase the number of PRCs to 6.	Services and Supports	10
Regional Psychogeriatric Coordination – The MOHLTC and the Seniors' Mental Health Programs, along with the NEMHC, should immediately begin to define the roles and responsibilities and the administrative structure of the Regional Psychogeriatric Coordination function followed by the funding of this infrastructure.	System Implementation	10
Chronic Care Units/Hospitals and Schedule 1 Facilities – These units/facilities should develop service	System	10

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protocols with specialized Psychogeriatric Outreach Teams.	Development	
Specialized Beds – The MOHLTC should immediately: a) Review the benchmarks for inpatient psychogeriatric beds (Tables 10.7, 10.8, & 10.9) and determine if these numbers will meet the needs of the districts in the region, and b) Collect and analyze utilization data in order to establish benchmarks for long stay specialized beds in the region.	Policy Implications	10
Specialized Units within Long-Term Care Facilities and Chronic Care Units – The MOHLTC should immediately begin: <ul style="list-style-type: none"> • Analysis of utilization data and profiles of persons with disruptive behaviours who no longer require highly specialized treatment (yet cannot be managed in a long-term care facility or chronic care unit) in order to establish benchmarks for staffing resources for specialized units within long-term care facilities and chronic care units, • Identification of the structural modifications required for these facilities to accommodate these persons' needs followed by detailed cost estimates, • Identification of potential sites for these units across the Northeast Region, and • Implementation planning for these beds. 	Policy Implications System Implementation	10
Specialized Outreach Services – Specialized outreach services that will be offered by the NEMHC should be fully funded and implemented immediately. There must be service agreements between the specialized level, chronic care units/hospitals, long-term care facilities and the community-based providers.	System Implementation	10
Recruitment and Retention of Health Human Resources – Additional financial resources are required to assist with the recruitment and retention of health care providers including French speaking and Aboriginal providers. Wage parity across all sectors is needed for stability within the system.	Policy Implications	10
New Health Human Resources – As new health human resources are added to the system, these resources should be allocated to existing agencies rather than creating new, stand alone services or programs. Furthermore, as additional or new front line positions are created (in order to expand mandates) within community mental health programs, there must also be adequate administrative supports for these positions.	System Implementation	10
Education/Training – Front line staff in different settings need additional education and training in order to enhance the level of expertise in caring for psychogeriatric individuals in local communities. Cross training would start with training staff about other agencies' services. Cross training about aging, mental illnesses and addictions is needed to provide service to people with multiple and complex long-term care needs. P.I.E.C.E.S. training should be available to staff working in psychogeriatrics in all settings (including staff in chronic care units/hospitals).	System Implementation Services and Supports	10

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<p>At the district level, there should be a comprehensive yearly assessment of the training needs of the mental health and long-term care providers, (taking into account the P.I.E.C.E.S. training) followed by the development of an integrated training plan for all sectors. The expertise of local providers should be utilized. The Regional Psychogeriatric Coordinator position would perform this assessment and review the roles and responsibilities of the different providers offering education in order to avoid duplication. The MOHLTC should provide additional funding for these education programs.</p>		
<p>Enhanced Client and Management Information Systems – Information systems should link costs to actual care. There is a need for electronic records and common health records. In addition, there is the recommendation made by the Northeast Mental Health Implementation Task Force, in its interim report of November 2000, which stated:</p> <p><i>“That appropriate funding be immediately explored by the MOHLTC to support development of a client linkage and management information system for the Northeast mental health system, in two phases:</i></p> <p><i>i) a pilot project being funded (estimated cost of \$300,000) specifically for Cochrane District building on the client information system developed by the Canadian Mental Health Association Timmins Branch to create a district-wide client and management information system that will later expand throughout the Northeast; and,</i></p> <p><i>ii) with completion of the pilot project, that full funding be given to each lead agency to participate in the client linkage and management information system for the Northeast mental health system estimated one-time cost of \$1.2 million and annualized cost of \$500,000).”</i></p>	System Implementation	10
SECTION 11: SPECIAL POPULATIONS		
<p>Implementation planning for the integrated mental health agencies should include local addiction services to ensure the development of coordinated strategies between these service systems for dealing with people who have concurrent disorders. In the interim, both types of providers at the local level in all five district clusters of the Northeast should develop a work group to address integration issues that can be moved forward. The levels of care template in this paper should serve as a planning tool in these discussions.</p>	System Implementation Services and Supports	11
<p>Both mental health and addiction services should screen for concurrent disorders and provide integrated service delivery based on the following principles:</p> <ul style="list-style-type: none"> • Service to those with a concurrent disorder is an expectation requiring a welcoming manner in all clinical contacts and empathic, hopeful, continuous, integrated support; • When substance disorder and psychiatric disorder coexist, each disorder should be considered primary, and integrated treatment will occur through formalized service agreements, partnerships and 	Services and Supports	11

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<ul style="list-style-type: none"> • amalgamations; • Each disorder receives appropriately intensive diagnosis-specific treatment; and • Each person must have individualized support according to their mental health and addictions needs, their phase of recovery and level of functioning and/or disability associated with each disorder. 		
<p>All mental health and addictions programs within existing funding, will have the capacity to provide concurrent disorder services which includes:</p> <ul style="list-style-type: none"> • Defined role for peer support; • Screening for both mental health and addictions; • Non-exclusionary criteria; and • On the job training to provide concurrent support and expectation that staff have a continuous learning mindset. 	Services and Supports	11
The MOHLTC will encourage delivery of joint cross sector training on concurrent disorders and treatment practices for all staff in addictions and mental health programs.	Policy Implications	11
The MOHLTC should support best practices research in the area of concurrent disorders with a immediate goal being the identification of effective assessment tools and clinical pathways to treat concurrent disorders.	Policy Implications	11
The NBPH/ NEMHC should fast track operationalization of the specialized concurrent disorder outreach team to serve the Northeast and that this be a priority focus as this type of team is vital to the full continuum of specialty services that should be available.	System Implementation	11
That District Health Councils assume the planning lead to work with the Regional Concurrent Disorders Program and district-based mental health and addiction service providers to develop in-depth regional and district implementation plans for this service area as soon as feasible. This would allow current staff in the Regional Program to focus on their team development. DHCs would ensure timely delivery of a comprehensive plan in the 2003/04 year.	System Implementation	11
That the MOHLTC and MCFCS accept joint responsibility for the funding of services required to provide accommodation and supports in the community for people with dual diagnosis.	Policy Implications	11
That the MOHLTC and MCFCS recognize and accept that persons with dual diagnosis will require ongoing (lifelong) supports, which in some cases will exceed \$150,000 per person per year.	Policy Implications	11
That for any new people entering the system for which a comprehensive assessment profile has not been completed, that one be done to provide the foundation for developing an individualized consumer needs-based plan.	Services and Supports	11
That dual diagnosis service providers involve families throughout the treatment and placement process.	Services and Supports	11
That service providers adopt the Best Practice Model of family focused case management for people with	Services and	11

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Recommendation	Type	Section
dual diagnosis.	Supports	
That the MOHLTC and MCFCS provide flexible funding that will support access when needed to physical health interventions such as that provided by Home Care.	Policy Implications	11
That the MOHLTC and MCFCS review salary funding policies to reduce the disparity between institution and community salary levels.	Policy Implications	11
That the MOHLTC, MCFCS and service providers develop and fund innovative and flexible approaches to resolve transportation hurdles in urban and rural settings.	Policy Implications	11
That one jointly funded position be developed in each integrated mental health agency to coordinate and facilitate person-centred planning and accountability.	Services and Supports System Implementation	11
That the integrated mental health agencies, Associations for Community Living, developmental support services, Schedule 1s and the NEMHC develop service agreements and protocols to effect prompt admissions to the dual diagnosis specialty program.	System Implementation	11
That the MOHLTC provide funding to fully staff the intensive support/ACT teams in the integrated mental health agencies such that there is additional capacity to serve people with dual diagnosis.	System Implementation Services and Supports	11
That the MOHLTC make funds available to evaluate the current model of regional/local dual diagnosis outreach for the purpose of identifying future enhancements and providing data for research of this model as an Ontario best practice.	System Implementation Policy Implications	11
Early detection and early intervention efforts should be accomplished through initiatives based in primary care settings with strong links to the school system. These efforts should be evidence-based and include evaluation and monitoring. They should include: <ul style="list-style-type: none"> • Education of providers and community members; • Supports for primary care providers; • New treatment models; • Access to formal referral center (e.g., children’s mental health service); • Introduction of a screening tool into primary care settings; • Assessments in schools and links with school personnel; • Links to emerging youth programs such as Youth Net in Ottawa; and • Following individuals over time to assess outcomes and to evaluate early intervention strategies 	System Implementation Services and Supports	11
The NEMHC should develop an early psychosis treatment program to be implemented across the Northeast. Innovative use of technologies and linkages with both child and adult mental health providers	System Implementation	11

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Recommendation	Type	Section
must be included. A partnership with one of the existing programs in the province should be pursued as soon as possible.		
The MOHLTC should make available seed funding to the Ontario Working Group on Early Intervention in Psychosis to develop a proposal that will see this capacity created in every region of the province including the Northeast.	Policy Implications	11
SECTION 12: HOSPITAL ROLES IN THE NORTHEAST SYSTEM		
All scheduled facilities include the components outlined in this section in their functional planning processes and that these basic elements must be funded accordingly. i) In 2003, the Ministry of Health and Long Term Care must develop an operational policy outlining the best practices and benchmarks, particularly with respect to appropriate staffing, for Schedule 1 facilities; ii) As directed by the Health Services Restructuring Commission, all scheduled services must be developed to build capacity for the population aged sixteen and over.	System Implementation	12
The current average length of stay (ALOS) for scheduled facilities must be reflective of system capacity: as the system transitions to new roles and mandates, the ALOS for scheduled facilities should not be limited to fifteen days or less until such time as the mental health system has restructured and other components of the reformed system are in place. Future ALOS should reflect case mixes, which are under current review through the JPPC initiative.	Policy Implications	12
It is recommended that every hospital in the Northeast must have a designated area where people coming to the emergency room with mental health issues can, if they choose, await assessment, along with their family, friends, workers and/or other support people. The MOHLTC and District Health Councils should review all hospital redevelopment functional plans to ensure this capacity is included. For other hospitals, appropriate renovations should be proposed. In the interim, all facilities should be encouraged to take the initiative to immediately allocate a designated area for people in mental health crisis.	System Implementation	12
The NEMHC (and NBPH until divestment) and the Schedule 1 hospitals should, as a first priority begin the development of formal service agreements, guided by the framework in this document. One time funding should be provided by the MOHLTC early in the 2003/04 fiscal year to support this project.	System Implementation	12
Formal service agreements and protocols must be developed between Schedule 1 hospitals and community hospitals in their respective catchment areas. As the integrated mental health agencies develop, formal agreements must also be put in place between the agencies and their local community hospitals. This work should build on the service agreements developed between the NEMHC and the Schedule 1 hospitals focusing on the newly defined roles in this report.	System Implementation	12
Community, Schedule 1 and the NEMHC should be included as members on district based transition committees that will address the formation of the integrated mental health agencies.	System Implementation	12 16

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Recommendation	Type	Section
Soldier's Memorial Hospital should be included in all regional discussions concerning the delivery of acute psychiatric care. This hospital should participate in all service agreements between the Schedule 1 hospitals, NEMHC and the integrated mental health agency (Muskoka/Parry Sound).	System Implementation	12
SECTION 13: INFORMATION SYSTEM AND TECHNOLOGIES		
Single Information System: That the Ministry of Health and Long-Term Care implement the development of a single information system for the Northeast that is partitioned internally in relation to the proposed integrated agencies allowing them to have "departmental" information sets to support their program and management functions. Such a system would support secure transmission of information, authorization protocols, authentication protocols, clear read, write and edit privileges and privacy protection.	Policy Implications	13
Scope of Information System: That the information system encompass all Ministry of Health and Long-Term Care funded mental health services including community mental health organizations, hospitals and other providers.	Policy Implications	13
Computer Automation: That the information system support automated collection of information and facilitate sharing information among service provider organizations for the purpose of service provision and coordination to individual people, to the extent possible in law, good practice and respect for confidentiality, using a "browser" based approach.	System Implementation	13
Relational Database: That the information system include a relational database coordinated with the provincial data sets. The relational database should facilitate and support reports and queries at the program service level, agency level and system level for the purposes of service delivery, program service development, management, accountability and planning. Further, it should, with appropriate permission and protection, support utilization for research purposes.	System Implementation	13
Funding: That mental health organizations require appropriate resources (i.e. ongoing and sufficient) to fund their information technology and system activities. Failure to address this matter will undermine the success of the mental health system.	Policy Implications	13
Information System Manager: The information system will require an entity to govern, develop and manage it. In keeping with the Smart System for Health decision to mandate a third party nongovernment information system provider entity we recommend that the same approach is followed for the mental health information system.	System Implementation	13
Population and Community Benchmarks: That the DHCs of Ontario, and for the Northeast, the Algoma, Cochrane, Manitoulin and Sudbury and Northern Shores DHCs, establish a set of population and community benchmarks in support of the performance indicators, system management processes and decisions of the regional mental health management body.	System Implementation	13
Both Official Languages: That the information system function in both French and English from its inception and be capable of aggregating all data as well as analysis (dis-aggregating) based on language	System Implementation	13

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Recommendation	Type	Section
of service. These capabilities will support both service provision and system management. The need for adaptation to First Nation languages should also be explored.		
Privacy Legislation: That the government move ahead with the proposed privacy legislation so as to create clear legal rules and regulations for the creation, storage, management and communication of health information that protect the interests of citizens while facilitating good health care and good health care management. This legislation and accompanying regulations would support the establishment of a matrix of policy, procedures, rules and controls of the information system.	Policy Implications	13
Provincial Lead for the Information System: That the MOHLTC respond immediately by creating provincial working group to review all existing mental health information systems and other related projects (e.g., the new additions information system, the E-CHIN) in the province, to assess how these independent systems might be brought together to create a provincial information system or to document the lessons these systems provide as to how such a project should proceed. This working group should also have the mandate to cross provincial and international borders to explore state of the art work on this issue such as that of the <i>Decision Support 2000+ A New Information System for Mental Health (2001)</i> a national project in the United States. This working group should assist the MOHLTC to prepare a comprehensive business case, in keeping with the government's directives to establish system accountability, for a province-wide mental health information system. Working group membership should include external stakeholders including individuals with mental illness and their families.	System Implementation	13
Regional Lead for the Information System: That the MOHLTC North Region Office convene a regional working group to assess the report on the information system pilot project and develop a detailed information plan for next steps to be taken in the region. As a minimum, this report should be shared internally with the MOHLTC corporate offices and be available to the provincial working group for consideration. Stakeholders from all levels of the Northeast system should be part of this regional working group. Notwithstanding provincial efforts to develop an information system, efforts in the Northeast should proceed in terms of developing a concrete implementation plan and costing for region-wide implementation. The work already completed through the pilot project should be considered the starting point for this regional project.	System Implementation	13
Optimum Funding for Specialty Outreach Services of NEMHC: That the MOHLTC ensure full consideration and funding of the specialty outreach services of the reformed NEMHC including technological hardware and software and related operational expenses and that this funding be secured through the divestment discussions in 2003.	System Implementation Supports and Services	13 11
SECTION 14: PERFORMANCE AND EVALUATION INDICATORS AND SYSTEM RESEARCH		
The MOHLTC must present a new business case to the government for funding that will support creation of an integrated mental health information system and full set of accountability measures to support a reformed mental health system.	Policy Implications	14

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Recommendation	Type	Section
Funding must be allocated to the Northeast Region, initially to the Regional Transition Team to be transferred to the NRMHB to customize its approach to performance indicators that will be used to evaluate the system and service changes. Evaluation must be funded up front with reports to be delivered on a regular basis to the MOHLTC.	System Implementation	14
On-going funding must be allocated to support ongoing research in the Northeast and to the development of increased linkages with universities and research units in the Northeast to foster an applied approach to mental health research questions. A knowledge generating mechanism must become the hallmark of this region's (and others too) reformed mental health system.	System Implementation	14
An immediate allocation should be made available to support the work of the district Transition Teams that will be responsible for drafting the initial principle, procedures and guidelines for operation of the integrated mental health agencies – to be based on the preliminary set of indicators proposed in this report.	System Implementation	14
SECTION 15: ADVOCACY		
That advocacy have a clear mandated role within the mental health system supported by legislated authority and funding.	System Implementation Policy Implications	15
That the MOHLTC develop, in consultation with the regions, a provincial framework for advocacy services. Consideration should be given to existing proposals (like that of the PPAO) and recommendations in the final reports of the Mental Health Implementation Task Forces. The framework should include the fulsome approach to advocacy and ombudsman roles defined in this report.	Policy Implications	15
The MOHLTC, in partnership with the Ministries of Citizenship, Education, Attorney General and Community, Family and Children's Services, establish the Mental Health Systems Provincial Consumer and Family Advocacy Office. This organization will: <ul style="list-style-type: none"> • Provides leadership and expertise in advocacy, including: <ul style="list-style-type: none"> ➤ The development of provincial regulations and standards; ➤ The creation of a Consumer Charter of Rights in consultation with the regions and driven by consumer input; ➤ The creation of a document on the "Principles for Meaningful Involvement of Families" in consultation with the regions and based on families' input; ➤ The development of training programs; 	System Implementation	15

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Recommendation	Type	Section
<ul style="list-style-type: none"> ➤ The development of information systems; ➤ Research on best practice; and ➤ Sharing of good practice. • Monitors provincial issues, trends and identifies system advocacy initiatives. • Monitors mental health policy and legislation development that impact on individuals' rights. • Inter-Ministerial support and funding. 		
<p>The MOHLTC in partnership with the Ministries of Citizenship, Education, Attorney General and Community, Family and Children's Services, establish the Northeast Mental Health Consumer and Family Advocacy Office. This organization will:</p> <ul style="list-style-type: none"> • Relationship with Mental Health Systems Manager – NRMHB or equivalent. • Complements and supplements existing institutional and community advocacy mechanisms. • Offers support and information to individuals with mental illness and their families. • Receives, investigates and resolves complaints. • Monitors outcomes of issues raised. • Promotes self advocacy. • Facilitates prompt access/referrals to appropriate advice/community resources or mediation as required. • Follows individual's instructions when providing services within agreed parameters. • Serves as a clearinghouse for the maintenance and dissemination of information related to advocacy and public education. <p>With respect to system advocacy:</p> <ul style="list-style-type: none"> • Flags systemic issues. • Works with the community to identify and address local needs. • Brings together stakeholders and works with existing networks to coordinate advocacy efforts and address systems issues. 	<p>Policy Implications System Implementation</p>	<p>15</p>

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Recommendation	Type	Section
<ul style="list-style-type: none"> • Reports on system issues on a regular basis to the regional system manager and annually to the Ministry of Health and Long-Term Care and other funders. • Monitors compliance with the Consumer Charter of Rights and the “Principles for Meaningful Involvement of Families”. <p>Multifunded and clear mandated role within the following Ministries:</p> <ul style="list-style-type: none"> • Citizenship; • Attorney General; • Health and Long-Term Care; • Community, Family and Children’s Services; • Education. <p>To include the following existing resources related to individual advocacy:</p> <ul style="list-style-type: none"> • Rights Advisors (inpatient, community treatment orders) • PPAO advocates (Expanded to include consumers and family in the community as well as inpatients). <p>Accountability:</p> <ul style="list-style-type: none"> • The advocacy service must monitor consumer satisfaction. • Accountability processes for the service should include standards of conduct and practice for advocates, performance appraisals and program reviews. • The service should provide reports on its activities to the regional systems manager and to funders on an annual basis, at a minimum. 		
SECTION 16: GOVERNANCE OF THE INTEGRATED AGENCY		
<p>The MOHLTC North Region will establish Interim District Transition Teams to facilitate the implementation of integrated mental health agencies in the four district clusters. DHCs will facilitate the process to receive recommendations for membership from each district within a four week period and submit a list of recommendations to the regional office. The transitions teams will:</p> <ul style="list-style-type: none"> • Be appointed by the MOHLTC for a period of 18 months to two years. 	System Implementation	16

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Recommendation	Type	Section
<ul style="list-style-type: none"> • Have eight to ten voluntary members and will reflect balanced representation from people with mental illness, families, providers and community across geography, district and diverse communities. • Expenses will be eligible for reimbursement by a special implementation fund provided by the MOHLTC. • Current executive directors and board chairs of community mental health transfer payment agencies will not be eligible for membership. • Membership will adopt a district-wide perspective and will reflect cultural/linguistic characteristics of the given district cluster. • Applicants for interim transition team membership will seek information about their understanding and commitment to a recovery process for people who experience mental illness; demonstrate experience in the following areas: working in a transition environment; past volunteer board experience; particular skills sets (e.g., mental health issues, human resources). • DHCs will have ex-officio membership on each transition team and will provide planning support. 		
<p>The Interim Transition Teams shall have a period of four months to review the three options for governance of the integrated agency and reach consensus on a recommended approach for four respective district clusters. This recommendation will be delivered to the MOHLTC - North Region for consideration. If consensus is not reached within the four month time frame, the MOHLTC will mandate the establishment of a new stand alone governance structure for the district integrated mental health agency. Work of the Transition Team will then continue based upon that decision.</p>	System Implementation	16
<p>During the remaining time period, the Interim Transition Team will focus on completing the following priority recommendations:</p> <ul style="list-style-type: none"> • Begin developing vision, values and principles encompassing the recovery approach for the agency; • Develop a work plan with set timeframes for the transition of existing programs into the new agency; • Refinement of recovery expectations in terms of individual and family outcomes; • Define consumer and family roles throughout service delivery, governance, evaluation and planning; • Ensure all actions are sensitive to the unique needs of people from Francophone, First Nation and other ethno-cultural communities; • Complete applications for incorporation of the integrated agency as a not-for-profit and charitable organization; • Undertake recruitment and hiring of the Chief Executive Officer • Develop a communications strategy for all stakeholders including frontline employees of existing mental health agencies; • Develop a financial plan for the new organization. 	System Implementation	16

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Recommendation	Type	Section
The Board of Directors for the Muskoka-Parry Sound Community Mental Health Service will provide a two-year work plan outlining the next steps in the further development of that organization as the integrated agency for those two districts. The plan will include detailed financial projections based on service development needs	System Implementation	16
A regional transition team will also be struck to oversee these district processes and focus on the development of the regional management body described in Section 14. In terms of overseeing the district processes, the regional team will serve as the change champion for the implementation process. Tasks will include: <ul style="list-style-type: none"> • Reviewing all district implementation plans to ensure both consistency in critical areas and that all plans reflect the uniqueness of the districts; • Identification of need for common elements across the integrated agency; standards, policies, reporting mechanisms, opportunities across all jurisdictions and facilitating their development; • Assisting the NEMHC with the evolving role of regional mental health service provider; • Further identification of education and training needs across the Northeast, especially those required to facilitate a smooth, caring and efficient transition process for all involved – people with mental illness, family members, frontline workers, administrative and management staff. 	System Implementation	16
The MOHLTC must allocate appropriate funding to provide flexibility in moving forward with the establishment of the transition teams and evolution of current services into the integrated agencies.	Policy Implications System Implementation	16
The MOHLTC provide a one-time grant of \$400,000 to the North East Ontario Network (NEON) to implement a regional training program that will prepare and support individuals with mental illness, family members and system partners for leadership roles within the reformed mental health system including membership on governing boards.	System Implementation	16
Following the regional training initiative, the MOHLTC should provide annualized funding for NEON to formalize the structure and role as the regional coordinating body for consumer initiatives and leadership across the Northeast. With a similar mandate, dedicated funding must be made available to formalize a family support network across the Northeast providing a forum for families to develop their roles and responsibilities within the reformed mental health system.	System Implementation	16
In order to align service and system boundaries, the MOHLTC should make the Northeast mental health system inclusive of the District of Muskoka and Parry Sound Districts for all levels of mental health service. The MOHLTC should direct that transitional plans be prepared at the proper time for realignment of the service boundary for specialty mental health care from the existing catchment areas of Penetanguishene Mental Health Centre and North Bay Psychiatric Hospital to the Northeast Mental	Policy Implications Services and Supports	16

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Recommendation	Type	Section
Health Centre. Further, the invitation should be extended to Soldier's Memorial Hospital to participate as a Schedule 1 hospital partner in the Northeast mental health system as outlined in this report.		
SECTION 17: SYSTEM MANAGEMENT		
The MOHLTC should immediately consolidate the management of and funding envelope for mental health services in the regional offices. In taking this step, the role for the Mental Health and Rehabilitation Policy Branch and Community Health Care Programs Branch would be to ensure that the regional offices have available enhanced mechanisms and funding to move ahead with the major recommendations for mental health system change and development. The system manager role would be supported by a representative committee of mental health system partners including people with mental illness, family members, mental health service providers and other health care and social services. This process should be evaluated from the onset with clear and realistic benchmarks for system reform being established.	Policy Implications	17
Should benchmarks for system reform not be met with the Regional Office of the MOHLTC serving as systems manager, the government and MOHLTC should endorse regional governance for mental health services and establish the North Region Mental Health Board (NRMHB) as a medium term mechanism to oversee regional mental health reform implementation.	Policy Implications	17
That a Regional Governance Transition Team be established to oversee development of the NRMHB.	System Implementation	17
The MOHLTC establish a provincial coordinating group to facilitate the development of a long-term provincial strategy for mental health promotion.	Policy Implications	17
Once established, the NRMHB will ensure implementation of a mental health promotion plan for the Northeast. This plan should build on the work of the Northeast Mental Health Public Education Campaign.	System Implementation	17
The MOHLTC should immediately initiate a provincial process to establish a funding formula for all mental health services.	Policy Implications System Implementation	17
SECTION 18: INNOVATIVE MENTAL HEALTH REFORM PROJECTS IN THE NORTHEAST		
The MOHLTC should review the interim and final reports of the Northeast Mental Health Public Education Campaign and determine the feasibility of renewing the funding in the Northeast and expanding the campaign across other regions in the province.	Policy Implications System Implementation	18
The Regional Steering Committee for the Campaign should be encouraged to disseminate widely the project evaluation results through conference presentations and publications in peer-reviewed journals. Lessons learned throughout the campaign should be fully documented and distributed for public review.	System Implementation	18
The Ministries of Education and Training, Colleges and Universities should immediately review the	Policy Implications	18

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Recommendation	Type	Section
<p>Nipissing University Proposal for funding of Phase 2 of the Development of Mental Health Resource Education Resources for Pre-Service Teachers and Experienced Educators. A response within the final quarter of the 2002/03 fiscal year would allow the University to proceed with the web-course development prior to the start of the 2003 fall semester.</p>		