

SECTION 1

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SECTION 1: INTRODUCTION

People with mental illness, families, policy makers, service providers and planners have identified the need to create more effective, comprehensive, and accountable mental health systems. Indeed, jurisdictions throughout the world have been challenged to redesign their mental health services. Ontario's mental health policy calls for reorientation of existing services to achieve an efficient and effective system where people will receive supports and services firmly grounded in best or "evidence-based" practice and according to their assessed need. The Health Services Restructuring Commission (HSRC) made wide sweeping recommendations about the divestment of the provincial psychiatric hospitals to the community hospital system as well as the need to focus the change process for mental health services at the regional and local levels. To this end, the government began establishing mental health implementation task forces, with the Northeast Task Force (NEMHITF) being the first one appointed in 1999.

At the same time, there is a growing body of evidence that demonstrates the efficacy of certain "best practice" approaches in the mental health field. Clinicians, people with mental illness and families have increasingly called for the use of practices with demonstrated effectiveness. In each system, the question is not **if** the system will attempt to employ these best practices with "demonstrable outcomes", but **when**. Ironically, the importance of creating efficient, effective, humane, and accountable systems of care is no longer questioned. Each constituency group, for their own reason, helps fuel the engine of change and innovation and ensure that over the next decade, we will see dramatic changes in how mental health services are delivered in the Canada, as well as in the United States, the United Kingdom, and in the other countries of Western Europe.

Coincident with the need for sweeping structural changes in the way that mental health care services are delivered, a number of governments, mental health systems, and local systems of care declared that their service delivery systems were based in a vision of recovery that evolved throughout the 1990s. (See Appendix One of this Section for the recovery system proclamation by the State of Connecticut.) **A recovery vision is grounded in the idea that people can recover from mental illness and that the service delivery system, therefore, must be constructed from this knowledge base and experience. To have a recovery vision is "to give the people we serve the hope of recovery"** (President's New Freedom Commission on Mental Health, 2002). In the past, mental health systems were based on the belief that people

with severe and persistent mental illness did not recover and that the course of their illness was essentially deteriorative or at best, one predicated on maintenance. Rehabilitation models tend to keep people at their current level of adjustment. The model tends to give the impression that the consumer will always have his or her problem. The solution in such a situation is to lean on the provider agency to help people with mental illness better manage their lives in the community. The rehabilitation model can foster living with your disability not recovering from it. In the worst case, a rehabilitation model fosters consumer dependency on the provider agency not real independence or interdependence in the community (Anlyan et. al., 1998).

The concept of recovery is important for tying together the various components in the mental health field into a single, powerful vision (Anthony, 1993). It is this concept that allows us to bring together the best of all approaches to work with people and facilitate their recovery journey so they have their desired quality of life. No one conceptual approach or discipline has all the answers – “there are few Renaissance people capable of mastering and employing all of the interventions required for over coming mental illnesses” (Lieberman, Hilty, Drake & Tsang, 2001). Furthermore, asserting the recovery vision for the Northeast mental health system means finding the way to include all participants - people who experience mental illness, their families and caregivers, many kinds of professionals, paraprofessionals, volunteers and communities – in a process that will enhance individuals “being, belonging and becoming” (Robeiro, Day, Semeniuk, O’Brien and Wilson, 2001). What we need to bring forward is the special knowledge, training, skills and experience, caring and healing spirit. What we need to exclude are heavily ingrained traits of some disciplines, like professional distance, emotional detachment, absolute authority, strict hierarchies, invulnerability and so forth that are grounded in the belief that people cannot live satisfying, fulfilling, contributing and hopeful lives in the community if they have a mental illness (Ragins, 1995).

As systems strive to create initiatives consistent with this important vision of recovery, new structures and new methods of accountability are needed to guide the development and evaluation of these significantly redefined systems of care. Based on the research that has been done on previous system initiatives and on the current consensus around accepted recovery practices and principles, a set of system standards are suggested to guide components of future system development in Northeast Ontario (adapted from Anthony, 2000).

This final report builds on the previous work done by the NEMHITF. In November 2000, the NEMHITF submitted advice to the Ministry of Health and Long-Term Care (MOHLTC) for review entitled *The Lead Agency Component in the Northeast Mental Health System: The Next Phase of Reform*, that boldly proposed a dramatic restructuring of services in Northeast Ontario. While the key recommendations in that report were endorsed in principle by the Minister of Health and Long-Term Care in January 2001, the resources required to begin the implementation were limited to two years of reinvestment funding that focused on expansion of the existing service continuums. The Task Force was also able to commission a number of key research reports in the ensuing two years. Being well ahead of the planning processes elsewhere in the province has had the unintended effect of delaying actual implementation here in the Northeast as the MOHLTC has waited for other Task Forces to complete their reports. In addition, the economic uncertainty of the last few years has resulted in very limited funding being available to support mental health reform.

The overall contributions of the Task Force are to be celebrated:

- A vision for a sustainable Northeast mental health care system based on principles of recovery has been articulated. The Northeast is the provincial leader in embracing this state-of-the-art vision. The roles for system partners are well defined and the connecting mechanisms required between the levels of care are identified.
- The Northeast has defined in detail how integrated mental health agencies, our goal for service integration, can be achieved. Once again, the early decision to embrace this approach has had the positive impact of raising the level of service integration debates in Task Forces throughout the province. Indeed, our conceptual work has been warmly received by international audiences through numerous speeches and conference presentations during the four-year mandate of the Task Force.
- Through the Provincial Forum of Mental Health Implementation Task Forces, the Northeast has participated in critical discussions on the overall agenda for mental health reform in the province. Key themes have been identified for consideration by the government including: adopting the recovery philosophy for Ontario's mental health services, implementing regional bodies for system management, creating system accountability to ensure system capabilities and operating performance by implementing a province-wide mental health

information system, creation of local transition teams to ensure mental health reform moves ahead when Task Forces are finished as well as creation of a provincial level transition team to champion mental health reform through the MOHLTC and the government.

- We have started the long-term process of building community capacity through the pilot Northeast Public Education Project that is aimed at community leaders. The project presents a convincing and compelling message that the community has both a role and responsibility to support people who have mental illnesses in their recovery processes. Using a community team approach, the project has been successful in involving people with mental illness, family members and service providers in speaking directly to community leaders about people who experience mental illness, the discrimination they face and their desire to belong in their own communities. Preliminary evaluation results suggest this strategy may prove effective for increasing community awareness and acceptance.
- We have engaged two partners in the post secondary education sector to address mental health reform. First, Nipissing University conducted a needs assessment study to develop mental health education resources for pre-service teachers and experienced educators. A second phase proposal for this project was submitted to the Ministries of Education and Training, Colleges and Universities for full funding in May, 2002. Final approval has yet to be received. Second, Canadore College has initiated a process to develop new curriculum for mental health and addictions workers using the recovery framework. The Task Force is very pleased with the interest and level of engagement these post secondary education partners have demonstrated in embracing the training needs for people who will work in and with the reformed Northeast mental health system.
- We now have research evidence (see Volume 2, Sections 2, 3 & 4) documenting the needs of people with mental illness throughout the region as well as the extent to which current services are able to provide people with the right kind of services at the appropriate time for only as long as they need them. These data support the proposed changes for service integration as well the need to create a system in which the levels of care are well coordinated.

1.1 Key Themes and Achievements in Moving Toward Implementation of the New System Design

The NEMHITF recommended the development of five integrated mental health agencies as the central component of the new system across the Northeast in its Interim Report to the Minister of Health and Long-Term Care. This recommendation was based on 20 years of system planning and service design, meeting the current policy and structures for adult mental health care in Ontario. The process of building a new vision for the system across the region has been challenging for all partners including people who have mental illness and families, mental health service providers, services in the broader health care sector and the MOHLTC. Systems change initiatives rely on trust and a certain willingness to assume a degree of risk. As it is impossible to accurately predict the result of these significant changes, it is critical that while all constituents have the opportunity for input, implementation be characterized by a “can do” attitude. It is only by having positive experiences with new ways that we learn what is possible. This is the essence of change.

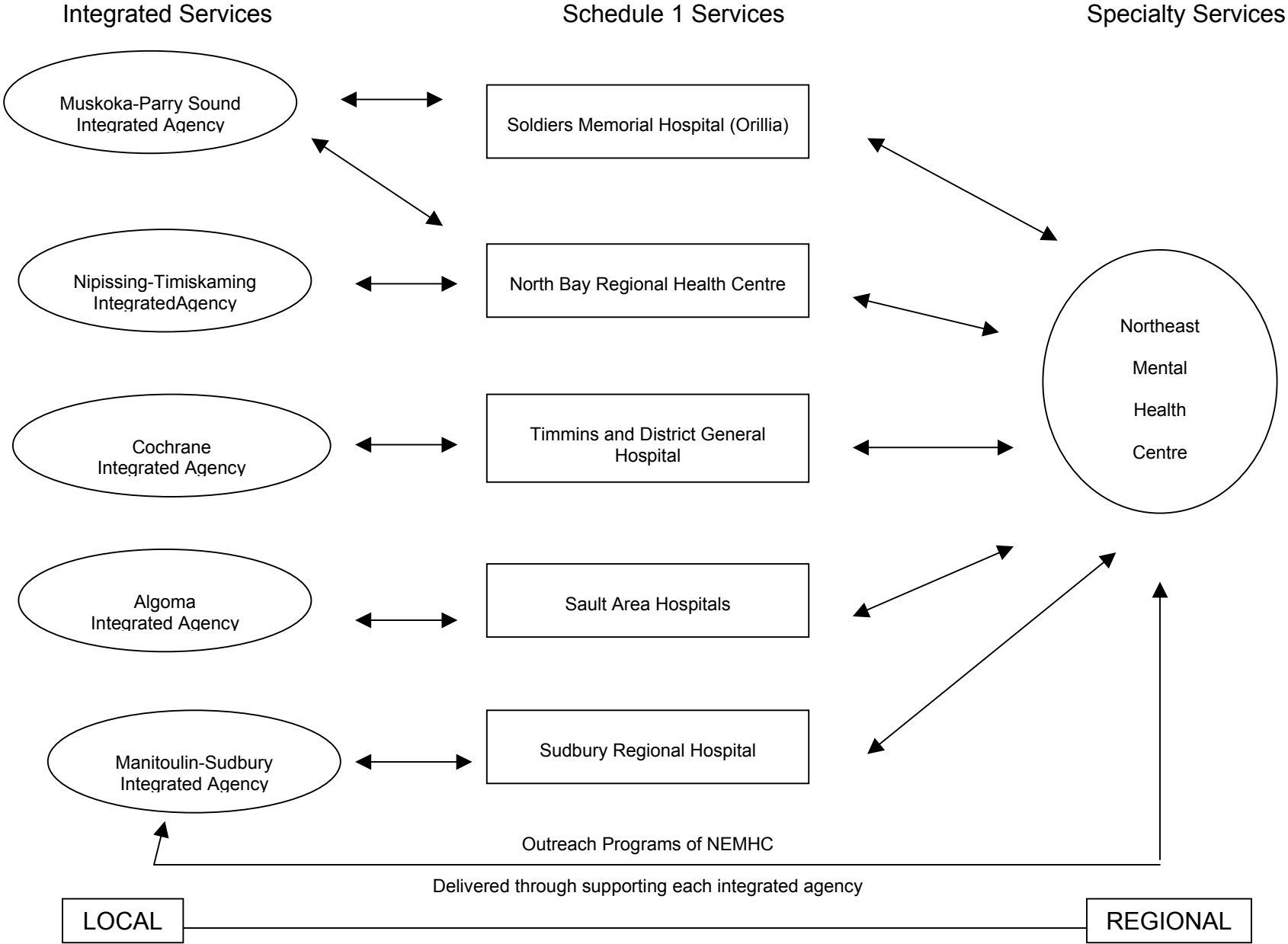
The NEMHITF’s intent with this final report is to acknowledge the historical challenges while presenting a new vision for the region’s people with mental illness, families, agencies and human service professionals and directors. There is within the proposed system, incentives to innovate, to create the vitality and momentum that will invigorate new processes and alliances, and foster new ways of thinking of service delivery approaches and delivery systems to support recovery for those experiencing serious mental illness. Our goal is to ensure that services and supports are available, responsive and flexible to meet consumer and family needs. Our hope is that all involved have the courage to take the many “leaps of faith” that will provide the foundation for enduring change. We are providing a plan that gives citizens of Northeast Ontario a clear vision of what an invigorated system will look like in the hope that this effort will provide the reassurance that change is possible, and that in this circumstance, is desirable.

It is clear that:

- The MOHLTC mental health policy endorses the following principles:
 - i) the person who has a mental illness is at the centre of the mental health system;
 - ii) services will be tailored to the individual’s needs with a view to increased quality of life;
 - iii) the individual’s choice and access to services will be improved;

- iv) services will be linked and coordinated so that people will move more easily from one part of the system to another;
 - v) services will be based on best practices and delivered within a quality improvement framework;
 - vi) mental health funding will continue to be protected; and
 - vii) there will be continued investments/reinvestments in mental health services to support mental health reform and increase the overall capacity of the mental health system.
- The MOHLTC goals for implementation plans are to ensure that core mental health services and supports:
 - i) are provided within a comprehensive service continuum developed to meet people's needs and based on best practices;
 - ii) are well integrated with the broader continuum of care provided by health and social services;
 - iii) are organized and coordinated based on a "levels of need" structure to ensure that people with mental illness have access to the services that best meet their needs;
 - iv) are appropriately linked to other services and supports within geographic areas;
 - v) facilitate a shared service approach to meeting the needs of individuals with serious mental illness who have multiple support needs;
 - vi) achieve clear system/service responsibility and accountability through the development of explicit operational goals and performance indicators; and
 - vii) are simplified and readily accessible, according to individual's needs.
 - The Minister of Health and Long-Term Care accepted the recommendations of the NEMHITF to establish five new integrated mental health agencies in the Northeast (Algoma, Cochrane, Manitoulin/Sudbury, Muskoka/Parry Sound, and Nipissing/Timiskaming), acknowledging that proposed functional and structural changes are true to the principles of mental health reform and will achieve the goals of reform. On a functional level, these agencies will integrate supports and services within each district cluster to ensure that people with mental illness and families have easy access and the means to obtain those supports and services according to need. The assessment/triage function in the integrated agencies is pivotal to the person receiving 1) the right type of supports in the 2) proper amount at the 3) right time from the 4) right individuals for the 5) necessary duration.

**FIGURE 1.1
NORTHEAST MENTAL HEALTH SYSTEM**



Structurally, the five integrated agencies form the community-based foundation of the new Northeast system of care, working in close partnership with community hospitals, Schedule 1 hospitals and the Northeast Mental Health Centre (see Figure 1.1). While the plan calls for the outright reduction in the number of stand-alone mental health agencies/programs across the Northeast, there will be no reduction in service delivery to people with mental illness. Integrated agencies will have the explicit responsibility to support as many people with serious mental illness as close to home as possible in their recovery processes. Furthermore, the interface of the integrated agencies to other health, social service, justice and correctional services in each area will be more clearly defined and streamlined.

- The Northeast Mental Health Centre has been established through the initial transformation of the Sudbury Algoma Hospital as per advice from the HSRC that was accepted by the Minister of Health and Long-Term Care. The Centre is to receive the assets of North Bay Psychiatric Hospital though the actual divestment date has been delayed by lack of funding. In the interim, the Centre has initiated consultations throughout the Northeast catchment area with regards to the type of inpatient services that should be available at its two sites. The Centre has also started discussions with Schedule 1 partners and community hospitals.
- There is a genuine interest to see that resources are used in an efficient and accountable way. As such, the goal of a recovery-focused system is to ensure that people with mental illness understand the limitations of the system while at the same time receive the appropriate service, at the appropriate site, from the appropriate person, for the appropriate amount of time. It is by attending to these issues of “flow in and out” of care that the system can be transformed from one that is perceived as providing “services for life” to one that can be reasonably expected to provide best practice interventions as necessary with the ability to be nimble enough to respond in the way most appropriate to the needs of the person versus in the way that is the most conducive to the service system. In this way, the system morphs from one that is provider-driven to one that is person-centred and responsive.

1.2 Implementation Focus

The NEMHITF believes that for the change process to succeed, we must:

- focus on the needs of people with mental illness and their families;

- encourage innovation to ensure the evolving recovery-oriented system is more efficient and effective and improves the quality of life of individuals with mental illness and their families;
- continue to debate and improve the linkages between the mental health system and the MOHLTC and other Ministerial partners: Ministry of Community, Family and Children's Services, Ministry of Public Safety, Ministry of Education, Ministry of Training, Colleges and Universities, Ministry of Housing, Ministry of Economic Development and Trade, and the Ministry of Northern Development and Mines;
- execute the change process, from where we are today in system development to where we want to be, in a caring, passionate and transparent way, such that all stakeholders, including people with mental illness and their families, employers, doctors, public and private sector organizations, and volunteers are actively involved in the debate and the incremental decisions as we move forward to achieve our collective goal;
- develop processes, including information systems, measurement systems, communication networks, bench marks and public education programs that are the best in the world; and
- create opportunities to export technologies and intellectual capital to the balance of Ontario, Canada and the world.

There is an increased awareness that the challenge of significant systems change activities in human service systems is much less a problem of knowing what ought to be done and more figuring out the process and strategy for implementing a change program. There are a number of reasons that can account for these phenomena. Change is difficult. Mental health providers, government, people with mental illness, and family members have become comfortable with many aspects of the current "delivery system" and the thought of changing some aspects of how individuals receive care is unnerving, both on a personal and systems basis. People become comfortable with their routines and roles. It can be a stretch to accept a new method of doing business, particularly if it challenges deeply or long held beliefs about potential outcomes and how things ought to occur.

The movement to a recovery-oriented system is a change that will challenge a number of commonly held twentieth century beliefs about the nature and course of mental illness.¹ It is important for the “change agents” to have a working knowledge of the literature that supports movement in the direction of a recovery-oriented system. The work of Courtney Harding (1987, 1994) presents empirical evidence accumulated across the last two decades to challenge long-held myths in psychiatry about schizophrenia that impinge upon the perception and thus the treatment of individuals. Such myths have been perpetuated across generations of trainees in each of the mental health disciplines. These myths limit the scope and effectiveness of treatments offered. These myths maintain the pessimism about outcomes for these individuals significantly reducing their opportunities for improvement and/or recovery. Counter evidence is provided with implications for new treatment strategies and approaches. In addition, the literature documenting recovery for people who experience mental illness is growing (Anthony, 1993, 1998, Anthony, Cohen & Farkas, 1990, Jacobsen & Curtis, 2000, Deegan, 1990, 1993 and 1996, Flexer & Soloman, 1993, Houghton, 1982, Leete, 1989).

Our responsibility in generating this final report is to provide information about a reconfigured system. We also hope to generate the momentum that will be required of all system partners – people who experience mental illness, families, the community mental health programs, community hospitals, Schedule 1 hospitals, the Northeast Mental Health Centre, the District Health Councils and Ministry of Health and Long-Term Care - as they work to develop the new system that includes integrated agencies in each of the five geographic areas. These agencies are a central component of the integrated system that, when added to other changes like enhancement of the system manager role, will strengthen the accountability and sustainability of the Northeast mental health system.

In attempting to develop a solid basis to help community partners make thoughtful and well-considered opinions, there are a number of key variables. Block (1998) states: 1) that problem solving requires valid data, 2) that decision-making requires free and open choice, and 3) that effective implementation requires internal commitment. The Task Force believes this final report provides a road map and a set of terms of reference for the transition to the new system. The vision is meant to generate an abiding commitment by all participants to the change

¹ Deegan (2002) documented that “recovery” was a recognized concept in mental asylums during the 1830s to 1870s, evidenced in the moral treatment movement. This thinking that people could recover went out of favour as the “somatatization” of mental illness and the rise of psychiatry as a distinct discipline within medicine resulted in a more narrowly defined illness paradigm for mental health issues.

process and to provide definition of terms, best practices, and range of acceptable alternatives to guide the tough decisions that have to be made. It is essential that an implementation process begin immediately and that there be no further recapitulation of the argument about whether Northeast Ontario should or should not pursue the integrated agency model. The discussion is much more clearly: “given that the MOHLTC and the NEMHITF have provided us with these parameters, here are the key decisions that we need to make in order to optimize our opportunity to achieve a successful outcome.” In the same way that the rhetoric supporting a consumer-centred system describes the principles that should be used in helping to plan a system of care for individuals with serious and persistent mental illness, it will be important to “walk the talk” by providing the system partners with the opportunity to address local differences, and to the extent possible, create an integrated system of care that will fulfil consumer and family needs. If we can be clear about the highly specific desired outcomes of the system and integrated agency implementation, it will be possible to create an accountability structure that will allow the system partners to go about achieving their outcomes in a manner that will result in the system as a whole learning about what works in the rural and remote northern region of Northeast Ontario.

1.3 Establishment of Mental Health Task Forces in Ontario

Mental health reform has been occurring across Ontario for over 20 years. The goal is to ensure people with a serious mental illness have easy access to a range of person centred services and supports as close to home as possible. People with mental illness are encouraged to set their own personal goals and acquire the skills and resources needed to increase independence and well being. The reform process has been guided by MOHLTC mental health policies including *Putting People First* (1994) and more recently *Making It Happen* (1999).

Although mental health reform has been occurring for over two decades, the following outcomes have not yet been realized:

- A system that is accountable, easy to access and appropriately supports flow, discharge, and re-entry;
- A shift from institutional care to a community-based system of supports and services;

- Seamless support and continuity of care within mental health and across related sectors;
- Community acceptance of people with serious mental illness;
- A range of housing and employment options;
- Full continuums of care within each district, across regions in the province based on best practices;
- Fewer people with mental illness in conflict with the law; and
- Funding formula for the province to ensure mental health receives an appropriate and equitable portion of the overall health care budget.

Mental health reform requires shifting a portion of existing resources from hospital to community services and supports. Ideally, the community should have 60% of the funding (MOHLTC, 1999). The increase in community capacity is expected to reduce reliance on hospital services. The HSRC's recommendations to divest specialty resources available in provincial psychiatric hospitals (PPHs) are intended to serve as a catalyst for the shift from hospital to community care. No bed closures will occur prior to community infrastructures being enhanced. To build full continuums of care, new and sustained investment in mental health services is required of the government.

The mental health system generally lacks capacity at all levels. This may result in inappropriate referrals to levels of care and inadequate matching of needs to service. Even when the services are available, lack of affordable transportation can impede access to support and opportunities to participate in community living.

In March 1999, the HSRC recommended Mental Health Implementation Task Forces (MHITFs) be established across the province as interim structures to define implementation plans to achieve the goals of mental health reform. The Task Forces will make recommendations specific to MOHLTC mental health programs and services. The requirements for cross-sector linkages with related systems will be identified where the individual has contact including corrections, community and social services and education. Task Forces will also make

recommendations to enhance adequate community service capacity as close to home as possible in preparation for restructuring of the PPHs. The goals are to develop a mental health system that is accessible, integrated and accountable.

The Minister established nine MHITFs: Northeast, Northwest, Champlain (Ottawa), Central South, Toronto-Peel, Southeast (Kingston), Central East (Whitby), Central East (Penetanguishene) and the Southwest. Each Task Force had the flexibility to evolve according to the implementation requirements of the region it serves.

1.4 Northeast Mental Health Implementation Task Force

The NEMHITF was announced in May of 1999. Once membership was established in the fall, the Task Force addressed the special request by the Minister of Health and Long-Term Care to revisit the siting and sizing of mental health beds in the Northeast system as well as the terms of reference directing the Task Force including that:

- The individual will be at the centre of the system and will have their needs met as close to home as possible;
- Individuals will have access to a comprehensive continuum of services that provide choices and are:
 - i) Organized and coordinated across “levels of need” to ensure that people have access to the services that best meet their needs;
 - ii) Integrated with the broader continuum of care provided by health and social services;
- People will be able to access the system easily since there will be fewer entry points, streamlined access and integration of service. Centralized information and referral mechanisms will be in place;
- People with multiple needs will have these met through a shared care approach within mental health and with related sectors. Protocols and service agreements will define roles, responsibilities and ensure accountability for service delivery, and to achieve specific consumer outcomes;

- People will have access to more service and support options through service realignment and reinvestment, based on best practices², and thus have more choice; and
- People will have an accountable system in which responsibilities are specified, outcomes and performance measures are defined in terms of the individual. Where outcomes are not met, changes will be made.

The work of the NEMHITF was based on a number of key assumptions:

- Individuals with severe mental illnesses can and do recover.
- Individuals with severe and complex mental health needs prefer to be supported as much as possible in their home communities.
- Individuals with severe and complex mental health needs require access to providers and support from related service sectors to meet their treatment, service and support needs.
- People with mental illness may move back and forth between community and inpatient care during alternating periods of illness and wellness.
- The MOHLTC will consider the mental health system balanced when the ratio of spending on community and inpatient services is 60/40.
- The MOHLTC will reinstate protected mental health funding until such time that local systems are appropriately funded.
- Mental health funding will be rationale and equitable such that the mental health sector receives the appropriate share of health care dollars reflecting the burden of mental illness on the overall population.

² Clarke Consulting Group, *Best Practices in Mental Health*, 1997 defined a best practice mental health system as including: multi-faceted individual support programs that include case management and assertive community treatment; crisis response system/psychiatric emergency system; housing/community support; inpatient/outpatient services; self-help and entrepreneurial initiatives; family self-help; vocational/educational services and social/recreational programs. The Federal, Provincial, Territorial Advisory Network on Mental Health, *Accountability and Performance Indicators for Mental Health Services and Supports* (2001) added early detection and primary care to best practice systems.

- There will be continued investments/reinvestments in services and supports to implement mental health reform and increase overall capacity of the mental health system.

The NEMHITF was guided by:

- the HSRC recommendations for Sudbury, North Bay and Parry Sound;
- Mental Health System Designs for the Districts of Algoma, Cochrane, Manitoulin-Sudbury, Muskoka-Parry Sound, Nipissing-Timiskaming;
- the Comprehensive Assessment Projects (CAP) completed on North Bay Psychiatric Hospital inpatients and outpatients and Sudbury Algoma Hospital inpatients;
- the Northeast Community Assessment Pilot Project;
- the Northeast Consumer Preference Study;
- the Muskoka-Parry Sound Community Mental Health Service Lead Agency Review;
- MOHLTC mental health policy *Making It Happen*;
- best practices and evidence-based support;
- community meetings, briefing, presentations, reports and research; and
- emerging and unmet needs.

1.5 Task Force Process

The NEMHITF undertook an ambitious schedule to address the full terms of reference and the special request by the Minister to revisit the siting and sizing advice for inpatient mental health services to be included in the Northeast mental health system. The year 2000 saw the NEMHITF submit its first round of advice in January, a proposal for a regional public education pilot project in May, and its Interim Report in November.

The Task Force wishes to acknowledge that the two decades of planning for mental health reform in the Northeast provided a solid and progressive foundation to launch its work. The Northeast Mental Health Steering Committee of the early 1980s and the six District Health Councils that produced mental health plans through the late 1980s and 1990s deserve a great deal of credit. The mental health system design reports issued in 1997 for the region and each of the districts/district clusters were based on best practices and documented the degree to which areas were able to address key issues of mental health reform. The Task Force worked from these reports and did not seek to revisit planning issues that had been debated and on which there had been significant and far reaching consultations.

Throughout this active phase, the NEMHITF used a working group structure among Task Force members to examine specific issues in-depth. As summarized in the Interim Report, four working groups were in place including one for housing, consumer and family issues, integrated agency development and public education. Advice from these workgroups has been incorporated throughout this final report.

The Task Force also undertook consultations in each district/district cluster in the Northeast inviting all established mental health stakeholders to present their views on the integrated mental health agency concept (see Appendix 3 in the Interim Report for a summary of these consultations). These presentations were conducted as part of regular Task Force meetings, with the membership travelling to each district. The Task Force also reviewed all correspondence, met with special interest groups that proposed different models, and were briefed regularly on emerging Ministry policy frameworks and new mental health developments. In addition, the Chairman and staff undertook additional visits and tours, including one to the James Bay Coast to gather additional information and insight on behalf of the Task Force.

The Task Force also built awareness and understanding of its mandate and work in the Northeast and the province, through a series of public presentations and an ongoing schedule of meetings with key officials in provincial government ministries. Visits to the Ministries of Health, Corrections, Community and Social Services, Education, Training Colleges and Universities, Northern Development and Mines, Housing and Minister Responsible for Children were completed. These outreach activities proved instrumental in creating an early momentum for the work of the Task Force.

Figure 1.2 presents a summary of the Task Force's milestones and critical events that have had an impact on the work of the Task Force. Table 1.1 presents the recommendations of the Task Force, Ministry responses to the recommendations and commentary as to the progress with implementation.

What is clear from the work of the Task Force is the need for firm commitment from the MOHLTC to move ahead with specific recommendations. The tension that arose in the latter years of Task Force discussions was simply that District Health Councils were not willing to take districts through detailed implementation planning processes in the absence of a formal announcement from the Ministry that existing community mental health programs would be amalgamated into these new agencies and resources be made available to support these processes. The Task Force also received proposals for the development of a stand-alone integrated agency for Francophones from the Hearst, Kapuskasing and Smooth Rock Falls Counselling Services and heard from others who were skeptical of the proposed changes. In the interim, additional reports important to the next phase of detailed implementation planning were completed, including the Muskoka-Parry Sound Community Mental Health Service Lead Agency Review and the Community Mental Health Program Audits. Unfortunately for the Northeast, the Task Force mandate was coming to a close and this final report had to be prepared without these detailed implementation plans being completed. The Task Force approach, at this juncture, is to present the final system design, and recommend a course of action to be undertaken when the government and MOHLTC are ready to proceed.

Figure 1.2
Northeast Mental Health Implementation Task Force
Milestones and Critical Events 1999 – 2002

Date	Milestones And Critical Events
May 1999	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> NEMHITF and Chairman announced by Minister Witmer <input checked="" type="checkbox"/> Membership announced
October 1999	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Work plan established <input checked="" type="checkbox"/> First meeting of NEMHITF <input checked="" type="checkbox"/> Siting and sizing issues reviewed <input checked="" type="checkbox"/> Orientation to Terms of Reference and existing mental health system plans <input checked="" type="checkbox"/> Initiation of Comprehensive Assessment Project <input checked="" type="checkbox"/> Initiation of Inter-Ministerial contacts with Corrections, Community and Social Services, Minister Responsible for Children, Education, Training, Colleges and Universities, Northern Development and Mines, Management Board
January 2000	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Housing, Public Education, Integrated Agency and Consumer and Family Workgroups defined and activated <input checked="" type="checkbox"/> Siting, sizing and initial system advice delivered to the Minister
March 2000	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Minister replies to first set of NEMHITF recommendations <input checked="" type="checkbox"/> Public Education Pilot Project proposal development gets underway with the Centre for Addiction and Mental Health and the Canadian Mental Health Association, Ontario Division <input checked="" type="checkbox"/> Begin stakeholder consultations
May 2000	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Comprehensive Assessment Project report received by NEMHITF <input checked="" type="checkbox"/> Initiation of Consumer Preferences Study
June 2000	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Minister announces \$1 million for Northeast Mental Health Public Education Pilot Project <input checked="" type="checkbox"/> Northeast Mental Health Centre (NEMHC) Board Incorporation <input checked="" type="checkbox"/> NEMHITF receives and supports Final Report from the Northeast Steering Committee – Child and Adolescent Specialized Psychiatric and Mental Health Services

Figure 1.2
Northeast Mental Health Implementation Task Force
Milestones and Critical Events 1999 – 2002

Date	Milestones And Critical Events
September 2000	<input checked="" type="checkbox"/> Nipissing University joins Public Education Pilot Project
	<input checked="" type="checkbox"/> Initiation of Community Capacity Pilot Project
	<input checked="" type="checkbox"/> NEMHC, NBPH and MOHLTC initiate divestment planning
October 2000	<input checked="" type="checkbox"/> Year 2 reinvestment decisions supported by NEMHITF
November 2000	<input checked="" type="checkbox"/> Interim Report and advice on Northeast Mental Health System delivered to the Minister
	<input checked="" type="checkbox"/> NEMHITF participates in Homes for People with Special Needs Consultation
December 2000	<input checked="" type="checkbox"/> Community Mental Health Program Audit process begins
January 2001	<input checked="" type="checkbox"/> Minister replies to Interim Report recommendations
	<input checked="" type="checkbox"/> Provincial Forum of MHITFs established, Chaired by NE Chairman
	<input checked="" type="checkbox"/> Ministry Implementation Team (MIT) Governance Committee formed to plan for the divestment of North Bay Psychiatric Hospital to NEMHC
	<input checked="" type="checkbox"/> Ongoing reports from Task Force Workgroups
March 2001	<input checked="" type="checkbox"/> Canadore College works with NEMHITF on development of new curriculum for mental health worker program
	<input checked="" type="checkbox"/> Year 2 of Public Education Project
April 2001	<input checked="" type="checkbox"/> Co-location Study funding approval – sent to NEMHC
May 2001	<input checked="" type="checkbox"/> Preliminary Report of Consumer Preferences Study
	<input checked="" type="checkbox"/> Preliminary Report of Community Capacity Pilot Project
	<input checked="" type="checkbox"/> Information system pilot project funding flowed to Canadian Mental Health Association Timmins Branch
June 2001	<input checked="" type="checkbox"/> NEMHITF, DHCs and MOHLTC North Region Office debate how to move detailed planning for integrated agencies ahead within each district
	<input checked="" type="checkbox"/> NEMHITF prepares detailed Integrated Agency Report
	<input checked="" type="checkbox"/> Year 3 reinvestment funding not approved by Management Board
	<input checked="" type="checkbox"/> Final Report of Consumer Preferences Study

Figure 1.2
 Northeast Mental Health Implementation Task Force
 Milestones and Critical Events 1999 – 2002

Date	Milestones And Critical Events
Summer 2001	<input checked="" type="checkbox"/> Final Report of Community Capacity Pilot Project
October 2001	<input checked="" type="checkbox"/> DHCs complete mental health housing studies
December 2001	<input checked="" type="checkbox"/> NEMHITF prepares position on regional system boundaries to share with Central East (Penetanguishene) Task Force
March 2002	<input checked="" type="checkbox"/> Community Mental Health Program audit data collection
April 2002	<input checked="" type="checkbox"/> OPSEU strike at NBPH: negative impact on NBPH patients, staff, management, system implementation planning, MOHLTC
June 2002	<input checked="" type="checkbox"/> Year 3 of Public Education Project
October 2002	<input checked="" type="checkbox"/> Community Mental Health Program audit report delayed
December 2002	<input checked="" type="checkbox"/> No agreement reached by NEMHITF, DHCs and MOHLTC North Region Office on how to move forward with integrated agency implementation
June 2002	<input checked="" type="checkbox"/> Functional Plan for NEMHC (North Bay site) and North Bay Regional Health Centre approved
October 2002	<input checked="" type="checkbox"/> MIT informed funds for NBPH divestment were not in 2002/03 budget; MIT work on hold.
December 2002	<input checked="" type="checkbox"/> Audit Report of Community Mental Health Programs received by the NEMHITF
December 2002	<input checked="" type="checkbox"/> Muskoka-Parry Sound Community Mental Health Service Integrated Agency Review received by NEMHITF
December 2002	<input checked="" type="checkbox"/> Final Report of NEMHITF submitted to the Minister

Table 1.1 NEMHITF Motions, Action Taken and Minister's Response, 1999-2001		
Approved Motions	Action Taken	Minister's Response
<p>MOTION PASSED JANUARY 11, 2000</p> <p>It was moved by Judy Shanks, seconded by Susan Adams that:</p> <p>In keeping with provincial policy, <i>Putting People First</i> and <i>Making It Happen</i>, the Northeast Mental Health Implementation Task Force is committed to a mental health system that has individuals who experience serious mental illness and their families at the centre. The Northeast Mental Health Implementation Task Force fully endorses a comprehensive, levels of care system of mental health services in Northeastern Ontario as defined in the Northeast Mental Health Systems Design. In keeping with the overall direction of health services integration and the work of the Health Services Restructuring Commission, the Task Force believes such a systems approach will balance the needs of people with mental illness and the needs of the public. This system also seeks to establish equitable and standardized delivery and access to care at all three levels of need [first-line, intensive and specialized; as defined in <i>Making It Happen</i>] across eight geographic districts and two district health councils. The challenges of delivering best practice-based mental health services in this territory demand that the principles of quality care, access, service effectiveness and efficiency will be best achieved through a system where regional, highly specialized inpatient and outreach treatment and rehabilitation services for</p>		

Table 1.1 NEMHITF Motions, Action Taken and Minister's Response, 1999-2001		
Approved Motions	Action Taken	Minister's Response
<p>children and adults are organized centrally while the major focus is placed on supports and services delivered in community-based integrated systems of mental health care organized at the local level.</p> <p>The Northeast Mental Health Implementation Task Force recommends to the Minister of Health and Long-Term Care that the following features be implemented:</p> <ol style="list-style-type: none"> 1. The new Northeast Mental Health Centre will focus on the delivery of long –term and specialized inpatient and outreach services for the Northeast Region. Operationally, the Centre will be linked to the district systems of care through standardized protocols and service mechanisms as outlined in the Northeast Mental Health Systems Design. 2. To achieve equity in the delivery of community mental health services within the Northeast mental health system at the district level, all community-based mental health services delivered by the North Bay Psychiatric Hospital and Sudbury Algoma Hospital/Network North should be referred to the following process over the period of the next two years (2000 – 2001). This process is consistent with the direction of integrating health services as defined in the <i>Northeastern Integrated Health System Task Force Report</i> (July 31, 1997) and the district and regional 	<p>NEMHC formed in June, 2000. Community consultation on roles has been conducted with interim and final summaries of the consultations...</p> <p>No community processes to plan “for a governance model for the district systems of care suitable to local partners” was completed in the two-year time frame, 2000 – 2001, in either Nipissing/Timiskaming or Sudbury/Manitoulin. Nipissing/Timiskaming had produced an implementation plan for a new community-based integrated agency in 1997. Sudbury/Manitoulin’s system design (1997) called for an affiliated integrated agency model with Network North as the lead for clinical services.</p> <p>NEMHC established a Standing Committee of the Board to oversee the provision of the community mental health</p>	<p>“The Ministry supports the Task Force recommendation which is consistent with the direction outlined in the Ministry’s <i>Making It Happen</i> paper.”</p> <p>“The Ministry supports in principle the Task Force recommendation. The Ministry will work with the Task Force and the Governance Steering Committee to develop a model of governance for mental health services and programs for Northeastern Ontario that is consistent with Ministry policy. This recommendation is consistent with the recommendations included in the Ministry’s <i>Making It Happen</i>” paper. The Governance Steering Committee, responsible for nominating the first Board of the Northeast Mental Health Centre, is comprised of representation from across Northeastern Ontario (Timmins, Sudbury,</p>

Table 1.1 NEMHITF Motions, Action Taken and Minister's Response, 1999-2001		
Approved Motions	Action Taken	Minister's Response
<p>mental health system designs. In the interim, the Northeast Mental Health Centre Board should establish not only the standing committee for the Network North community health programs as directed by the Health Services Restructuring Commission but also a similar standing committee for the community-based programs formerly provided by the North Bay Psychiatric Hospital. The composition of the standing committees should include at least one board member and representation from appropriate stakeholders including consumer and family representatives. Clear Terms of Reference should be established setting out the standing committees' roles and responsibilities for overseeing the provision of the community programs and reporting to the Board. A governance model for the Sudbury and Manitoulin district system of care suitable to all local partners and the Ministry of Health and Long-Term Care must be developed. A lead agency model is recommended. A governance model for the Nipissing District system of care suitable to all local partners and the Ministry of Health and Long-Term Care must be developed. A lead agency model is recommended.</p>	<p>programs it operates in Sudbury/Manitoulin. Terms of Reference have been established. Since divestment of NBPH has not taken place, a similar Standing Committee has yet to be established for the community mental health programs that the NBPH/ NEMHC operates in North Bay. Draft Terms of Reference have been prepared by NEMHC.</p>	<p>North Bay and Sault Ste. Marie.) The Governance Steering Committee is currently working to develop the governance structure of the Northeast Mental Health Centre. The Ministry will review the plan to ensure that it is consistent with the HSRC direction and Task Force recommendations.</p>
<p>3. The Task Force supports a regional board of governance for the</p>	<p>NEMHC Board was established in June, 2000.</p>	<p>The Ministry supports the Task Force recommendation. The HSRC directed the Sudbury</p>

**Table 1.1
NEMHITF Motions, Action Taken and Minister's Response, 1999-2001**

Approved Motions	Action Taken	Minister's Response																		
<p>Northeast Mental Health Centre.</p> <p>4. The inpatient portion of the system should be sized as follows:</p> <table border="0"> <tr> <td>Kind of Bed</td> <td># of Beds</td> </tr> <tr> <td>Long-Term Adult Beds – North Bay</td> <td>61</td> </tr> <tr> <td>Long-Term Beds – Sudbury</td> <td>31</td> </tr> <tr> <td>Forensic Adult Beds – North Bay</td> <td>52</td> </tr> <tr> <td>Acute Adult Beds – North Bay</td> <td>40</td> </tr> <tr> <td>Acute Adult Beds – Sault Ste Marie</td> <td>23</td> </tr> <tr> <td>Acute Adult Beds – Sudbury</td> <td>39</td> </tr> <tr> <td>Acute Adult Beds – Timmins</td> <td>16</td> </tr> <tr> <td>Northeastern Child/Adolescent Specialized Sudbury</td> <td>20</td> </tr> </table>	Kind of Bed	# of Beds	Long-Term Adult Beds – North Bay	61	Long-Term Beds – Sudbury	31	Forensic Adult Beds – North Bay	52	Acute Adult Beds – North Bay	40	Acute Adult Beds – Sault Ste Marie	23	Acute Adult Beds – Sudbury	39	Acute Adult Beds – Timmins	16	Northeastern Child/Adolescent Specialized Sudbury	20		<p>Algoma Hospital to reconstitute itself as the Northeast Mental Health Centre with a governance structure representative of the Northeastern Ontario region, having regard for demographic, cultural, religious, economic, linguistic, ethnic and social characteristics of the region.</p> <p>The Ministry supports in principle the sizing and composition of beds recommended by the Northeast Mental Health Implementation Task Force. The work of the Task Force permits planning to begin on a number of important health care projects in Northeastern Ontario. In order to determine the specific impact of the Task Force's recommendation, further work needs to be done to outline the capital and operating funding requirements associated with the sizing and siting recommendations of the Task Force.</p>
Kind of Bed	# of Beds																			
Long-Term Adult Beds – North Bay	61																			
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Northeastern Child/Adolescent Specialized Sudbury	20																			
<p>5. A new pavilion for acute, long-term and children's mental health services under the Northeast Mental Health Centre and Sudbury Regional Hospital should be built in Sudbury at the Sudbury Regional Hospital site to facilitate delivery of best practice-based care. The Task Force recommends this pavilion and associated planning costs be funded 100% by the Ministry of Health and Long-Term Care. A feasibility study will be immediately required, including capital costs.</p>	<p>Subsequent motion of the NEMHITF, dated March 6, 2001 handed over this issue to the NEMHC Board. Feasibility study was completed (Insert date) and delivered to the NEMHC Board. No action has been taken. Final Report from the consultants has not yet been finalized. Steering Committee to meet again in July 2002 to finalize.</p>	<p>The Ministry will provide up to \$200,000 to conduct a feasibility study with the Northeast Mental Health Centre, Northeast Mental Health Implementation Task Force and Sudbury Regional Hospital, to determine the operating and capital cost impact/feasibility of consolidating acute long-term and children's mental health services on the site of the Sudbury Regional Hospital. The Ministry capital cost sharing provides 100% funding of long-term mental health beds in Sudbury and 70% capital funding for specialized adolescent psychiatric beds and</p>																		

Table 1.1 NEMHITF Motions, Action Taken and Minister's Response, 1999-2001		
Approved Motions	Action Taken	Minister's Response
<p>6. A feasibility study will be immediately required, including capital costs, for the recommended forensic and acute bed increases in North Bay.</p>	<p>Work was completed as part of the overall function plan for the combined NEMHC/NBGH facility. Functional plan was approved May 29, 2002.</p>	<p>adult acute psychiatric beds not transferred from a provincial psychiatric hospital.</p> <p>The Ministry supports in principle the recommended increase in forensic beds. The Ministry will work with the Northeast Mental Health Implementation Task Force, North Bay General Hospital and the Northeast Mental Health Centre in order to identify the operating and capital cost implications of the recommended increase in the number of forensic beds located in North Bay. The Ministry will provide 100% of the planning costs for this study as part of the development of the North Bay General Hospital/Northeast Mental Health Centre Pavilion. After developing and reviewing preliminary estimates of capital and operating costs the Ministry will confirm its additional contribution to the capital development of the Northeast Mental Health Centre (North Bay campus) for the forensic beds and the North Bay General Hospital for acute beds.</p>
<p>7. In keeping with the directions of the Health Services Restructuring Commission, all Schedule 1 (mental health) hospitals, namely Sault Area Hospitals, Timmins and District Hospital, Sudbury Regional Hospital and North Bay General Hospital, should develop strong linkages and begin implementation of a plan with the Northeast Mental Health Centre providing for: a contract between the Centre and each contracting hospital under which</p>	<p>NEMHC has initiated planning work with the Schedule 1 hospitals. A draft report has been prepared for presentation to the NEMHITF.</p>	<p>The Ministry supports the Task Force recommendation.</p>

Table 1.1
NEMHITF Motions, Action Taken and Minister's Response, 1999-2001

Approved Motions	Action Taken	Minister's Response
<p>patients of the contracting hospital will have equitable access to long-term mental health services; and manpower, program and patient care linkages between the Centre and the contracting hospital to improve the quality of mental health services.</p> <p>8. The Task Force will submit a detailed plan to integrate mental health services in the Northeast that will focus on individuals who suffer with serious mental illness and their families, recommend district lead agency models across all districts (Algoma, Cochrane, Manitoulin/Sudbury, Muskoka/Parry Sound, Nipissing/Timiskaming) for the delivery of mental health treatment services as well as enhance the availability of other necessary support services, development of appropriate information technology, increase accessibility by clearly defining entry points to the system, eliminate duplication of functional services and reduce competition for limited resources.</p> <p>9. The Task Force will, in partnership with provincial mental health organizations, develop a plan for a public education campaign to address the stigma attached to, and fears of, mental illness, promote the integration of individuals who suffer with mental illness in their communities, as well as support a proactive/preventive</p>	<p>NEMHITF submitted its Interim Report to the Minister in November, 2000. Minister's reply was received February, 2001. See motions listed later in this table.</p> <p>Project proposal was submitted in May, 2000 and Minister announced funding in June, 2000 for a five-year, pilot project. Implementation began under the auspices of the NEMHC Fall of 2000. Project has completed two full years of operation and has plans for the remaining years.</p>	<p>The Ministry supports the Task Force recommendation which is consistent with the principles contained within the Ministry's <i>Making It Happen</i> paper. Using information technology to support the integration of services between community providers and institutional providers is consistent with Ministry initiatives to develop smart systems and smart cards.</p> <p>The Ministry supports the Task Force recommendation.</p>

**Table 1.1
NEMHITF Motions, Action Taken and Minister's Response, 1999-2001**

Approved Motions	Action Taken	Minister's Response
<p>approach to mental health issues for all people across their lifespan.</p> <p>10. The Task Force will submit a detailed financial reinvestment strategy that will allocate regional savings to frontline services, determine the amount of transitional funding required to implement the system design and identify equity funding needs. We support the principle that no beds be closed until appropriate community supports are in place.</p>	<p>To be completed as part of the NEMHITF Final Report.</p>	<p>The Ministry supports the Task Force's role in determining the allocation of the community resources provided by the Ministry and the principle that no beds will be closed until the appropriate community supports are in place. Savings as a result of the implementation of HSRC directions (including bed closures) will return to the Ministry of Health and Long-Term Care. The Ministry will provide the community with resources to provide for frontline services for alternatives to inpatient care.</p>
<p>11. In the spirit of service integration, the Task Force recommends that the delivery and funding for children's mental health services be transferred to the Ministry of Health and Long-Term Care from the Ministry of Community and Social Services. This will allow for a holistic approach to serving all individuals with serious mental health concerns and promote a proactive and supportive continuum of services to those most in need across their lifespan.</p>	<p>NEMHITF sent a letter to the Minister of Community and Social Services and subsequently met with the Minister. No Ministerial action has taken place.</p>	<p>Since the recommendation is beyond the Terms of Reference for the Task Force, the Ministry would ask the Task Force to forward the recommendations and supporting information to the Minister of Community and Social Services for information and consideration.</p>
<p>12. The Northeast Mental Health Implementation Task Force and the Governance Steering Committee representing the Northeast Mental Health Centre be immediately acknowledged by the Ministry of Health and Long-Term Care so as to be provided the</p>	<p>Deputy Minister presented on psychiatric hospital divestment formula to the Task Force on January 10, 2000 providing assurance that funding concerns for the NEMHC would be addressed.</p>	<p>The Ministry greatly appreciates and values the work of the Task Force and its membership. The Ministry, through the Regional Office and the Health Reform Implementation Team, will work closely with the Task Force to ensure it has opportunities to be consulted and to provide input into Ministry processes relating</p>

Table 1.1 NEMHITF Motions, Action Taken and Minister's Response, 1999-2001		
Approved Motions	Action Taken	Minister's Response
<p>opportunity to participate in all Ministry committees relating to mental health reform, psychiatric hospital divestment and any other related issues.</p>		<p>to Mental Health Reform, psychiatric hospital divestment and any other related issues.</p> <p>The Ministry of Health and Long-Term Care has concluded discussions establishing principles for the transfer of responsibility for provincial psychiatric hospitals to the public hospital sector. The application of these principles will serve as the foundation of the local agreements negotiated through the Ministry Implementation Team – Governance Committee. The Northeast Mental Health Centre will have the opportunity to discuss concerns with the Ministry of Health and Long-Term Care in this forum.</p>
<p>MOTION PASSED MAY 9, 2000</p> <p>It was moved by Peter Deane, seconded by Judy Shanks that a letter be forwarded to the Minister of Health and Long-Term Care recommending another course of action regarding the feasibility study on co-location as the Sudbury Regional Hospital Board chose not to support the study and that a copy be sent to Sudbury Regional Hospital.</p> <p>MOTION PASSED OCTOBER 3, 2000</p> <p>It was moved by Mark Hurst, seconded by Maxine Bridges that the NEMHC consider a motion to support the feasibility study for co-location in Sudbury.</p> <p>MOTION PASSED MARCH 6, 2001</p> <p>It was moved by Peter Deane, seconded by Judy Shanks that</p>	<p>Letter was sent May 9, 2000.</p>	<p>Ministry letter dated April 3, 2001 addressed to Jean Trimnell approving the one-time funding for the co-location feasibility study was received.</p>

Table 1.1 NEMHITF Motions, Action Taken and Minister's Response, 1999-2001		
Approved Motions	Action Taken	Minister's Response
the Task Force ask the Northeast Mental Health Centre and its Board to assume the management of the co-location study from the Northeast Mental Health Implementation Task Force.		
MOTION PASSED MAY 9, 2002 It was moved by Marc Morin, seconded by John Follis that the Task Force accept the public education strategy in principle and that the project move ahead.	Public education proposal was submitted to the Minister under the auspices of the Task Force, CMHA Ontario Division and the Centre for Addiction and Mental Health.	Minister announced funding of the pilot project in June, 2000.
MOTION PASSED MAY 9, 2000 Re: Proposed Tracking Study of Occupational Movement proposed by the City of North Bay: It was moved by Joe deMora, seconded by Mark Hurst that the Task Force will undertake to lead a human resource strategy for mental health reform in the Northeast in cooperation with appropriate representatives of Canada Manpower, North Bay General Hospital, North Bay Psychiatric Hospital and the City of North Bay and other partners as required.	This study was not completed.	Ministry initially allocated funding for this study. The funding was subsequently redirected.
MOTION PASSED OCTOBER 3, 2000 It was moved by Maxine Bridges, seconded by Gaetan Malette that the Task Force agree in principle with the draft interim report recommending five lead agencies in the Northeast as discussed and amended.	This advice was incorporated in the revisions of the Interim Report.	
MOTION PASSED NOVEMBER 7, 2000 It was moved by Susan Adams, seconded by Judy Shanks that	Advice was delivered to the Minister of Health and Long-	Minister's reply received January 29, 2001.

Table 1.1 NEMHITF Motions, Action Taken and Minister's Response, 1999-2001		
Approved Motions	Action Taken	Minister's Response
the second draft of the Interim Report be approved with the amendments that were discussed by the Task Force and that the document be forwarded to the Minister of Health and Long-Term Care as soon as possible.	Term Care November 10, 2000.	
<p>Interim Report Recommendations:</p> <p>13. That the lead agency concept in the Northeast be fully endorsed based on the design for establishing an equitable system of care across the entire region. District lead agencies need to be on equal footing with each other and have standardized relationships with the Schedule 1 hospitals and regional mental health centre. The endorsement is critical to the work that still needs to be done in those districts that have not made any progress towards system development and service integration. The message must be delivered that a district lead agency is the end goal towards which they must move.</p> <p>14. That the Algoma, Cochrane, Manitoulin and Sudbury District Health Council immediately facilitate planning for lead agency development in the districts/district clusters of Algoma, Cochrane and Manitoulin/Sudbury and the Northern Shores District</p>	<p>Planning has not commenced. Terms of Reference have not been established and instead the Task Force continued to define the definition of integrated agency.</p>	<p>The Northeast concept of integrated agency as described in the <i>Integrated Agency Component in the Northeast Mental Health System: The Next Phase of Reform</i> represents significant streamlining of access to mental health services and supports. In light of anticipated future service demands in the evolving community-based system in the Northeast the Ministry supports the Task Force's concept of integrated agency for the provision of mental health services.</p> <p><i>Making It Happen</i> identifies lead agencies as one of three mechanisms which may be used to streamline access to mental health services and supports. The Ministry of Health and Long-Term Care is currently developing a program policy for streamlined access to mental health services and supports and will be consulting on this framework early in 2001.</p> <p>The Ministry supports the Task Force recommendation. The North Region Office will work with the Task Force and the Algoma, Cochrane, Manitoulin and Sudbury District Health Council and the Northern Shores District Health Council to operationalize this recommendation. Clear Terms</p>

Table 1.1 NEMHITF Motions, Action Taken and Minister's Response, 1999-2001		
Approved Motions	Action Taken	Minister's Response
<p>Health Council facilitate planning for lead agency development in the district cluster of Nipissing/ Timiskaming and evaluation of the Muskoka/Parry Sound lead agency. The plans for each lead agency will include a detailed implementation strategy to be completed for submission with the final Northeast Mental Health Implementation Task Force report to the Minister in 2001.</p>		<p>of Reference outlining the Ministry requirements will be drafted prior to the Councils engaging their respective districts in dialogue. Councils will initiate this implementation strategy by district clusters within six weeks of the request to proceed.</p>
<p>15. That policy and appropriate funding be immediately explored by the Ministry of Health and Long-Term Care and the Northeast Implementation Task Force to support the development of a single governance structure for all mental health agencies within each district/district cluster as a first step in moving to implementation of lead agencies in each district/district cluster.</p>	<p>Ministry initiated program audits in the fall of 2001. The final report on these program audits is being submitted to the Ministry early July, 2002.</p> <p>Within the North Region, fifty transfer payment agencies were reviewed. Individualized letters with findings/recommendations were forwarded to the Board Chairperson (April 15, 2002) and where indicated, a response of a remedial action plan was due by June 1st. All action plans have been received from agencies within the Northeast. Final report was received October, 2002.</p>	<p>The Ministry supports, in principle, this Task Force recommendation. The North Region office will assume responsibility for coordinating this examination of an appropriate funding mechanism for a integrated agency model. Examination will include a review of current budget information; intensive program reviews; input through the District Health Councils of district implementation plans; and comparison with similar projects. Further, the MOHLTC will undertake a zero-based budgeting approach for the Northeast area throughout this restructuring process.</p> <p>The Ministry is currently developing a program policy for streamlined access to mental health services and supports and will be consulting on this framework in early 2001. The Ministry will continue to work with the North Region Office to ensure the forthcoming policy on streamlined access to mental health services and the development of funding mechanisms for integrated agencies maintain consistency.</p>

Table 1.1 NEMHITF Motions, Action Taken and Minister's Response, 1999-2001		
Approved Motions	Action Taken	Minister's Response
<p>16. That appropriate funding be immediately explored by the Ministry of Health and Long-Term Care to support development of a client linkage and management information system for the Northeast mental health system, in two phases:</p> <p>i) a pilot project being funded (estimated cost of \$300,000) specifically for Cochrane District building on the client linkage 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</p> <p>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.</p>	<p>\$300,000 one-time funding was flowed to the Canadian Mental Health Association Cochrane Timiskaming Branch to support this Cochrane district pilot project in May 2001. A mid-year progress report was received. The Manager of Regional Operations, IT Cluster, North Region conducted an on-site review of the data management system in February 2002. He was scheduled to present his findings to the NEMHITF in the spring but the meeting was cancelled. There was also a meeting with the IT Manager, NEMHC to initiate the review of the needs of the mental health system from a regional perspective and determine the fit between the pilot project and the proposed regional system.</p> <p>Transfer Service Agreements are scheduled to be sent to all community mental health transfer payment agencies this summer and will be due back to the regional offices in September 2002.</p>	<p>The Ministry has reviewed the information system developed by the Canadian Mental Health Association (CMHA) Timmins Branch in relation to information requirements for Assertive Community Treatment Teams (CMHA Timmins sponsors two teams). The Operational Support Branch found the system very compatible with both the requirements of Assertive Community Treatment Teams and the larger minimum data set already piloted and anticipated to be implemented across the province. The Ministry supports, in principle, the information system and its application in a regional context. A detailed review of Phase 2 in the proposal would have to be undertaken in relation to the rollout of the Minimum Data Set before approving the larger initiative.</p> <p>The Ministry is in the process of developing a provincial accountability framework for community mental health programs and services. It will be important to ensure that the information system identified for the Northeast is consistent with the accountability framework.</p>
<p>17. That the following district-specific recommendations be accepted:</p> <p>i) that the Ministry of Health and Long-Term Care undertake an independent evaluation of Muskoka-Parry Sound Community Mental Health Service as a comprehensive lead agency to create a</p>	<p>The evaluation of Muskoka-Parry Sound Community Mental Health Services started in March 2002. This report is expected to be completed in July 2002. Task Force and Ministry staff have been participating in an advisory capacity on this project.</p> <p>The Ministry initiated program audits in the fall of 2001. The</p>	<p>The Ministry supports both components of this recommendation. The North Region Office will coordinate both the independent evaluation of the Muskoka-Parry Sound Community Mental Health Service as well as a comprehensive program review/audits on all other mental health transfer payment</p>

Table 1.1 NEMHITF Motions, Action Taken and Minister's Response, 1999-2001		
Approved Motions	Action Taken	Minister's Response
<p>benchmark for an integrated lead agency model in which a single board manages and delivers the majority of adult mental health services throughout the defined catchment area; and</p> <p>ii) that program review/audits be conducted in the remaining districts to determine the status of current mental health programs to permit the Northeast Mental Health Implementation Task Force and the Ministry of Health and Long-Term Care to make effective and efficient reinvestment decisions.</p> <p>18. That the Ministry of Health and Long-Term Care give consideration to the reinvestment strategy to be submitted by the Northeast Mental Health Implementation Task Force in its final report, including:</p> <p>i) funding for new (or where they exist, enhanced) system components specifically housing and supports to housing, rehabilitation services and consumer and family initiatives; and</p> <p>ii) funding for current system components be upgraded through the reinvestment process to meet best practice service standards and/or provincial benchmarks. This may require special funding to acknowledge the historic under funding of mental health services in Northeastern Ontario.</p>	<p>Centre for Addiction and Mental Health conducted the data collection. District Health Councils have been writing the final reports and these are being submitted to the Ministry in early July, 2002. The Task Force has yet to see the report.</p> <p>The process was initiated in December 2000 with development of the evaluation instrument. Data collection began in December 2001. The final report was received in the Task Force Office October 2002.</p>	<p>agencies.</p> <p>The Ministry supports, in principle, this recommendation. The Task Force, in conjunction with the North Region Office, will provide advice on future directions for the reinvestment strategy.</p>

Table 1.1 NEMHITF Motions, Action Taken and Minister's Response, 1999-2001		
Approved Motions	Action Taken	Minister's Response
<p>MOTION PASSED NOVEMBER 7, 2000</p> <p>It was moved by Kelly Van Raalte, seconded by Marc Morin that the comments made to the Ministry of Health and Long-Term Care on their new policy direction in housing for persons with mental illness be accepted.</p>	<p>Advice was delivered through the Ministry's consultation on Homes For Persons with Special Needs.</p>	<p>New policy has yet to be finalized. Minister wrote to the Task Force on December 10, 2001 asking them to further review the need for a full range of housing in its final report.</p>
<p>MOTION PASSED MARCH 1, 2001</p> <p>It was moved by Peter Deane, seconded by Richard Christie that the Northeast Mental Health Implementation Task Force recommend that the Northeast mental health system be inclusive of the Districts of Muskoka and Parry Sound for all levels of mental health care, that a transition plan be prepared 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 Health Centre and that Orillia Soldiers' Memorial Hospital be invited to participate as a Schedule 1 hospital partner in the Northeast mental health system.</p>	<p>This recommendation will be included in the Final Report of the Task Force.</p> <p>Task Force staff was invited to attend a meeting of the Central East – Penetanguishene Task Force to explain this position on changing the service boundary on May 23, 2002.</p>	
<p>MOTION PASSED MARCH 1, 2002</p> <p>It was moved by John Follis, seconded by Rayudu Koka that the Northeast Mental Health Implementation Task Force support the request from the Northern Initiative for Social Action for additional funding and that the Regional Director of the North Office of the Ministry of Health and Long-Term Care be advised of our support.</p>	<p>Ministry was informed of the Task Force motion via verbal communication.</p>	<p>NISA has received approval from MOHLTC to utilize in-year operating fund surplus (as a result of delayed implementation of ACTT #2 Nipissing) to support NISA with one time funding. Their operation will continue through the end of the 2002/03 fiscal year.</p>

1.6 References

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APPENDIX 1.1

September 10, 2002

Effective Date: September 17, 2002

Commissioner's Policy Statement No. 83 Promoting a Recovery-Oriented Service System

Purpose

The purpose of this policy is to formally designate the concept of "recovery" as the overarching goal of the service system operated and funded by the Department of Mental Health and Addiction Services ("Department"). This action is consistent with the fact that the Department is a healthcare service agency. Thus, it is most appropriate that one should hope and expect that, as a result of active involvement with this healthcare system, they will be better able to manage their illness and improve the quality of their life.

Policy Statement:

The concept of recovery shall be the guiding principle and operational framework for the system of care provided by the partnership of state and private agencies and consumer-run services that comprise the Department's healthcare system. Services within this system shall identify and build upon each recovering individual's strengths and areas of health in addressing his or her needs. The environment for this system shall encourage hope and emphasize individual dignity and respect. As one of its foremost priorities, the Department shall promote recovery for persons at risk of, or who have psychiatric or substance use disorders by creating a recovery-oriented service system.

Recovery is a process rather than an event. Thus, the service system shall address the needs of people over time and across different levels of disability. Recovery principles shall be applied to the full range of engagement, intervention, treatment, rehabilitative and supportive services that a person may need. Recovery principles shall also be applied to health promotion and prevention services for those at risk of mental illness or of substance use disorders, especially those for whom selected or indicated prevention strategies are appropriate.

The concept of recovery is embodied in the Recovery Core Values articulated by the addiction and mental health recovery communities in Connecticut. In keeping with this vision, and in partnership with the recovery communities, the Department shall create new and make necessary revisions to existing policies, procedures, programs, and services, and shall ensure that all new initiatives are consistent with a recovery-oriented service system. Finally, the Department shall ensure that future strategic planning and resource development efforts build upon existing strengths and continue to move the Department in the direction of promoting recovery as a core concept. In so doing, we shall firmly embed the language, spirit, and culture of recovery throughout the system of services, in our interactions with one another and with those persons and families who trust us with their care.

The recovery-oriented service system shall be notable for its quality. It thus will be marked by a high degree of accessibility, effectiveness in engaging and retaining persons in care such that they can achieve the highest degree of stability and recovery, and its effects shall be sustained rather than solely crisis-oriented or short-lived. To attain this level of quality, the recovery-oriented service system shall be age and gender appropriate, culturally competent, and attend to trauma and other factors known to

impact on one's recovery. Whenever possible, services shall be provided within the person's own community setting, using the person's natural supports. The service system shall help the person to achieve an improved sense of mastery over his or her condition and assist the person to regain a meaningful, constructive sense of membership in the community.

Definition:

“Recovery” is a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding one's life despite, or within the limitations imposed by that condition.

Recovery is a person-centered approach and it thus may vary from person to person and within the mental health and addiction communities. Just a few examples of recovery include:

- Returning to a healthy state evidenced by improving one's mood and outlook on life following an episode of depression;
- Managing one's illness such that the person can live independently and have meaningful employment and healthy social relationships;
- Reducing the painful effects of trauma through a process of healing;
- Attaining or restoring a desired state such as achieving sustained sobriety;
- Building on personal strengths to offset the adverse effects of a disability.

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Department of Mental Health and Addiction Services
State of Connecticut, (2002)