Legislative Assembly of Ontario

Assemblée législative de l'Ontario

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMMUNITY MENTAL HEALTH

(Section 3.06, 2008 Annual Report of the Auditor General of Ontario)

2nd Session, 39th Parliament
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Legislative Assembly of Ontario

Assemblée législative de l'Ontario

The Honourable Steve Peters, MPP
Speaker of the Legislative Assembly

Sir,

Your Standing Committee on Public Accounts has the honour to present its Report and commends it to the House.

Norman W. Sterling, MPP
Chair

Queen's Park
May 2010

STANDING COMMITTEE ON PUBLIC ACCOUNTS

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2nd Session, 39th Parliament

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LIST OF CHANGES TO COMMITTEE MEMBERSHIP

LAURA ALBANESE was replaced by DAVID RAMSAY on September 15, 2009.

ERNIE HARDEMAN was replaced by TED ARNOTT on September 15, 2009.

TED ARNOTT was replaced by PETER SHURMAN on February 24, 2010.

PHIL MCNEELY was replaced by AILEEN CARROLL on March 9, 2010.

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LIST OF SELECTED ABBREVIATIONS

ACT	Assertive Community Treatment
CMH	Community Mental Health
CTO	Community Treatment Order
ICM	Intensive Case Management
IHSP	Integrated Health Service Plan
LHINs	Local Health Integration Networks
MOHLTC	Ministry of Health and Long-Term Care
SMI	serious mental illness; or (the) seriously mentally ill

INTRODUCTION

According to the Ministry of Health and Long-Term Care, the community mental health sector is more integrated, expanded, and accessible than it was in the past although its delivery system is more articulated and complex than other sectors of healthcare. There is much broader variation in the choice of client treatment and services, ranging from intense acute care, medication management, and supported activities in the community such as employment and housing. Yet despite this, the Committee perceives that the community mental health sector has been poorly resourced relative to its complex needs; it has been called the "poor cousin" of the healthcare system. While the Ministry has determined that the mental-health system should achieve a spending target of 60% on community-based services to 40% on in-patient services, the Auditor General (Auditor) observed in his recent audit that the reverse is true. The Ministry spent about $40 on community-based services for every $60 it spent on institutional services in 2006/07. The Auditor's observations have been noted by the Ministry, namely, that there is not, as yet, an adequate community-based system to support people who suffer from serious mental illness. The government, the Minister, and the Legislature all share this view.

In February 2009, the Standing Committee on Public Accounts held an afternoon of public hearings on community mental health.[1] The topic of this hearing—also the subject of an audit in the *2008 Annual Report* of the Auditor General, drew before the Committee six community mental health service providers, representatives of three local health integration networks—the Central, Champlain, and South-West LHINs—and officials from the Ministry of Health and Long-Term Care. (For a transcript of proceedings, see Committee *Hansard*, February 18, 2009.) This report highlights the Auditor's observations and recommendations contained in Sec. 3.06, and presents the Committee's own findings, views, and recommendations.

The Committee endorses the Auditor's findings and recommendations and thanks the Auditor and his team for drawing attention to these important issues pertaining to mental health services throughout Ontario communities and within the LHINs.

OVERVIEW

LHINs Assume Responsibility for Community Mental Health

The *Local Health System Integration Act, 2006* established 14 Local Health Integration Networks (LHINs) responsible for the effective and efficient management of the health-care system locally. Effective April 1, 2007, the

[1] During its public hearings on February 18, the Committee was informed that the Legislature was in the process of forming a Select Committee on Mental Health that is expected to report its findings in 2010. The terms of reference of the Select Committee can be accessed in *Hansard* at http://www.ontla.on.ca/web/committee-proceedings/committees_detail.do?locale=en&detailPage=mandate&ID=7790

Ministry of Health and Long-Term Care (Ministry) closed its seven regional offices and transferred their responsibilities to either the LHINs or new areas within the Ministry. Community mental health (CMH) service providers began reporting directly to their respective LHINs rather than to the Ministry. But as the Committee notes later in this report, some confusion remains around the reporting function. The LHINs assumed responsibility for prioritizing, planning, and funding selected health-care services including community mental health services.

Ministry-LHIN Accountability Agreements

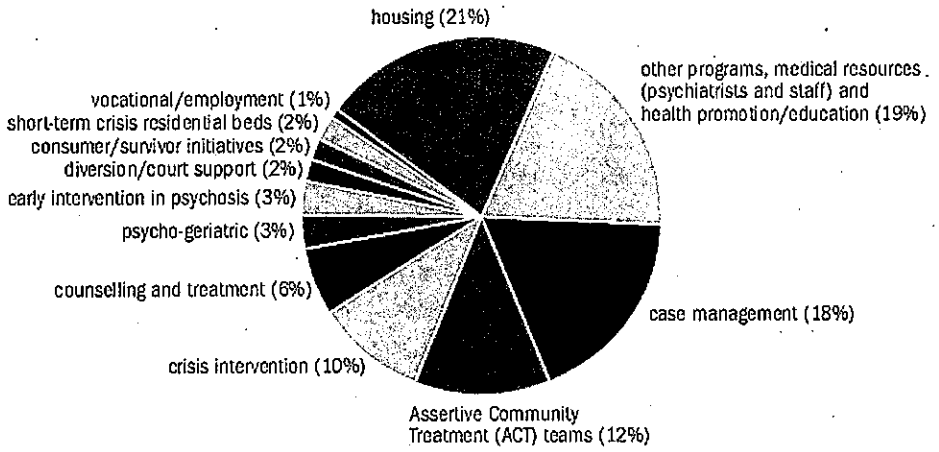
Each Ministry-LHIN Accountability Agreement sets out the relationship between the Ministry and the LHIN. The Ministry provides transfer payments to the LHINs which, in turn, fund about 330 community-based service providers of mental-health services.

Funding and Expenditures

Funding for community mental health totalled about $647 million in the 2007/08 fiscal year, ($595 million in 2006/07) up from $390 million in 2001/02, the time of the Auditor's last audit. The components of Community Mental Health Expenditures for the 2006/07 year (%) are as follows:

Components of Community Mental Health Expenditures 2006/07 (%)

Source of data: Ministry of Health and Long-Term Care



Ministry Mental Health Policy Re-direction

The Ministry began funding community-based mental health services in 1976, when mental health policy evolved from one of institutional care in psychiatric hospitals to one focused more on community-based care. Since 1998, the Ministry has divested its 10 provincial psychiatric hospitals (PPHs) to the public hospital system to allow for the coordination and delivery of mental-health services to be overseen at the local community level.[2] Community mental health programs treat the estimated 2.5% of the population, 16 years and over, who suffer from a serious mental illness (SMI).

OBJECTIVES AND SCOPE OF THE AUDIT

The Committee welcomed the opportunity to review the Auditor's first audit of the CMH sector where under the Auditor's recently expanded mandate, the Auditor could audit the community service providers.[3] In this most recent audit, the objective was to assess whether the partnership of the Ministry, the LHINs, and the community-based service providers had mechanisms structured to

- meet peoples' service needs for mental health treatment;
- monitor payments and services, ensuring compliance with legislation, agreements and policies; and
- measure and report on the effectiveness of the partnership's community mental health programs.

While the Auditor's staff met with Ministry personnel and stakeholder groups, the focus of the audit was at the three LHINs (Central, Champlain, and South West) and the six CMH service providers, two from each of the three LHINs.

The Auditor expressed concern in the 2002 and 1997 audits over the lack of clear provincial expectations for the level of community-based services that people with serious mental illness could expect to receive. As well, there was a lack of

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[2] The arms' length Health Services Restructuring Commission (HSRC) provided final advice to the Minister of Health for 9 of the 10 PPHs as part of the overall hospital and health services restructuring in the province. The advice recommended the transfer of management and governance of the PPHs to various existing or newly created public hospital corporations. In the case of the 10th hospital, the Mental Health Centre Penetanguishene (MHCP), however, the HSRC provided only general advice that it be transferred to a public hospital corporation without specific directions with respect to a receiving hospital. Source: Legal Services Branch, Ministry of Health and Long Term Care (September 28, 2009). In 1998 Queen Street Mental Health Centre was the first PPH to be divested. It was transferred to the Centre for Addiction and Mental Health. In 2008, the MHCP was the 10th and final PPH to be divested to a public hospital corporation (which operates under the same name). See Ministry of Health and Long-Term Care, Communications and Information Branch, "Mental health centre divestment strengthens local governance and keeps with ministry's stewardship mandate," *New Directions* (October 27, 2008), pp. 1-2.

[3] The Auditor's previous audits took place in 1987, 1997, and 2002 and did not include the community service providers.

information on whether the level of care provided by community-based service providers was sufficient to enable clients to live fulfilling lives in their local communities.

ISSUES RAISED IN THE AUDIT AND BEFORE THE COMMITTEE

In the current audit, the Auditor noted that while the Ministry has made some progress in the current audit, many of the Auditor's earlier concerns have not yet been adequately addressed. The Ministry has successfully reduced the number of mentally ill in institutions, but noted that the ultimate success of this strategy depends upon adequate community-based support systems. The Auditor concluded that over the years, the agencies have operated with considerable autonomy which has resulted in a patchwork of services across the province. As highlighted below, several significant issues were raised by the audit and identified by the Committee.

Access to Services

Making it Happen, a key mental health policy document released by the Ministry in 1999, stated that each person with an SMI should have access to treatment, rehabilitation, and support services.

While there has been significant progress in the CMH sector of today, timely access to appropriate community mental health care is not always available across the province. All stakeholders recognize that more work is needed to transform mental health services into a comprehensive system that puts the person first, is barrier free, and is easier to access and navigate. Excluding the supportive housing programs, this sector had wait times of about 180 days on average, ranging from a minimum of eight weeks to a year or more.

The Auditor recommended that the Ministry improve coordination with the LHINs and other ministries involved in serving people with mental illness. Furthermore, the LHINs should work with service providers to improve the reliability of wait-list and wait-time information and use such information to determine the need for prioritizing specific types and levels of service.

Wait Lists and other Community Mental Health Access Issues

During the public hearings, the Committee heard that constituents have contacted Members' offices to express concern about the lack of timely access to services from local mental health service providers. Committee Members asked the Ministry who is accountable for ensuring such access—the service provider, the LHIN, or the Ministry? During discussions the Ministry indicated that since the provider has a service agreement with the LHIN, the service provider would be accountable for providing access. When it was further disclosed that the provider had pointed to resource limitations and the creation of a waiting list for the service, it was suggested that the Members follow-up on any concerns with the LHIN.

The Standing Committee on Public Accounts recommends that:

1. **The Ministry of Health and Long Term Care in consultation with the LHINs report to the Standing Committee confirming that they are developing provincial benchmarks such as wait times for community mental health services. The report should indicate the steps required and the time horizon for this initiative. Lastly, the report should indicate whether reporting of wait time targets is now (or will be) a component of the service accountability agreements between the LHINs and the community mental health service providers.**

Members also drew the Committee's attention to difficulties experienced by their constituents when seeking timely and appropriate crisis services for a relative or friend who may not realize that he or she is suffering from a serious mental illness and may be a danger to self or others. Members highlighted recent news articles on this topic. One involved a man who, having become isolated died alone in his apartment. Members asked the Ministry whether these and other examples, frequently reported in the press, might justify a change to Ontario's mental health laws, recognizing the need to protect both the seriously mentally ill and society.

The Legislature last looked at this matter in 2000 when it amended the *Mental Health Act* to allow community treatment orders (CTOs).[4] The Ministry said that it has not been strongly pressured from the public or the treatment community to amend that aspect of the legislation and therefore perceives the current statutory regime to be appropriate.

The Standing Committee on Public Accounts recommends that:

2. **The Ministry of Health and Long-Term Care report to the Standing Committee (i) whether in its view the *Mental Health Act* can adequately meet the needs of those who seek appropriate services for seriously mentally ill persons who refuse treatment or who pose a danger to self and others; and (ii) whether the Ministry keeps statistics about the lack of appropriate services in such circumstances.**

Coordination of Access to Services

Making It Happen, the 1999 policy document, stated that access to "mental health services in Ontario can be confusing and time-consuming for clients and their families/key supports." A decade later, this continues to be an issue. In 2008, the Auditor observed a lack of formal coordination and collaboration among the key stakeholders: CMH service providers, the relevant ministries, and the LHINs. A key reason for creating the LHINs arose from Ministry concerns over lack of coordination and integration of services in the CMH sector. In essence, to many

[4] The purpose of a community treatment order is to provide a person who suffers from an SMI with a plan for community-based treatment or care and supervision that is less restrictive than being detained in a psychiatric facility. For more information on community treatment orders, see Ontario, Office of the Auditor General, *2008 Annual Report* (Toronto: The Office, December 2008), pp. 192-3.

people, the sector could be a confusing system of many service providers and multiple access points.

The Auditor recommended that the Ministry improve coordination with the LHINs and other ministries serving people with mental illness. He further recommended that the Ministry provide support to the LHINs, particularly in terms of knowledge transfer and data availability, to enable the LHINs to effectively coordinate and oversee service providers. He also noted that the providers will look to the LHINs for leadership in providing the necessary assistance to enhance coordination and collaboration among health service providers.

During the public hearings, the Committee heard about inter-ministry coordination and collaboration initiatives including best practices. The Ministry indicated that there is a great deal of inter-ministerial cooperation, as well as cooperation between LHINs and municipalities. The Committee heard about initiatives in criminal justice through the Ministry of the Attorney General and the Ministry of Community Safety and Correctional Services involving forensic mental health and court diversion programs. Another example of inter-ministerial cooperation exists between the Ministry of Community and Social Services (MCSS) and the Ministry of Health and Long-Term Care (MOHLTC) on the dual diagnosis population—developmentally handicapped people who also suffer from mental illness.[5] A new joint policy guideline has recently been published to clarify responsibilities between the two ministries when working with these clients.[6] Though the MCSS has the lead responsibility, it is supported actively by the MOHLTC through LHINs and local providers.

Members asked about the sector's most vulnerable clients—those who suffer from mental illness and live in shelters, group homes, the streets, and who are largely "lost to the system." Members wondered how those clients might obtain appropriate and timely mental health services given the sector's somewhat confusing system and multiple access points.

One of the witnesses pointed out that when leaving a shelter or group home, those with serious mental illness often become the responsibility of the emergency workers (police, ambulance attendants, the emergency departments of local hospitals). She highlighted an intriguing statistic— the London city police

[5] The National Association for the Dually Diagnosed (NADD) estimates that 30% of the population with a developmental disability also has a mental health disorder. Using the NADD figure of 30%, it is estimated that there are approximately 37,620 individuals with a dual diagnosis in Ontario.

[6] Ministry of Health and Long-Term Care (MOHLTC) and Ministry of Community and Social Services' (MCCS) *Joint Policy Guideline for the Provision of Community Mental Health and Developmental Services for Adults with a Dual Diagnosis* (December 2008). Internet site at http://www.health.gov.on.ca/english/providers/pub/mental/joint_policy_guideline.pdf accessed January 2009. Services for adults age 18 and older with a dual diagnosis are a responsibility shared by both ministries. Planning for youth ages 16 and 17 with a dual diagnosis is shared by both MOHLTC and MCCS to work with the Ministry of Children and Youth Services (MCYS) which has responsibility for development and mental health services for children and youth under age 18.

respond to twice as many mental-health related calls as they do to car accidents with injuries. In her view, this situation calls out for the collective efforts of all ministries at the bureaucratic level to develop ways of diverting such clients away from hospital emergency rooms and the criminal justice system and towards suitable community mental health services.

According to other witnesses, these situations call for the strengthening of intensive case management as well as collaboration and cooperation with multiple providers and stakeholders. Witnesses noted that the Ontario health care system tends to perform poorly when faced with transitions from one provider to another, and this problem is not unique to mental health. The LHINs recognize the system's shortcomings and would like to bring the players together to build a comprehensive system that is patient-centred—to ensure a smooth transition of clients from one provider to the next.

Some Committee Members suggested that health care professionals in the CMH sector and those in long-term-care homes might form working partnerships to help train staff in the homes to more effectively manage dementia among the residents. The Committee heard that in one of the LHINs, a well-known psychiatrist has started educating the staff about the needs of residents suffering from dementia. The Ministry argued that while there is a need for staff training and education, it is more important to address this need among residents of the long-term care homes rather than try to create the referral mechanisms with the psychiatric community outside the homes.

The Standing Committee on Public Accounts recommends that:

3. **The Ministry of Health and Long-Term Care in consultation with the Ministry of Community and Social Services report to the Standing Committee providing a status report on the new joint policy guideline for provision of community mental health and developmental services for adults with a dual diagnosis. Specifically, the Committee is interested in knowing:**

   - **how well the new guideline is working in the field to assist service providers in helping those with a developmental disability who have mental health needs;**
   - **whether the Ministries of Health and Long-Term Care and Community and Social Services are clear as to their respective responsibilities and are successfully coordinating their services to serve these individuals; and**
   - **at what point will the effectiveness of the joint guidelines be assessed by the two ministries.**

4. **The LHINs should report to the Standing Committee on how they plan to achieve integrated mental health services. The report should address transitions between all the players in the system; whether**

they have considered establishing a single point of entry for people seeking access; and if so, an estimate of the timeframe involved.

5. **The Ministry of Health and Long-Term Care should consult with the Ministry of Community Safety and Correctional Services (MCSCS) and report back to the Standing Committee as to the following:**

   - **whether MCSCS gathers statistics from local police services, (including the Ontario Provincial Police) that keep track of trends concerning interactions between the police and mentally ill persons in crisis situations; and**
   - **what kind of training is available to help police learn how to interact skilfully and professionally in all situations involving serious mentally ill persons in the community.**

Funding

Community mental health expenditures rose from $409 million in 2003/04 to $647 million in 2007/08. This 58% increase resulted from four-year federal "Accord" funding which allocated $117 million and two-year provincial "Service Enhancement" funding which allocated $50 million. The Accord funding expanded services in crisis intervention, intensive case management, early intervention in psychosis, and Assertive Community Treatment (ACT) Teams. The Service Enhancement investments are intended to keep SMI persons out of the criminal justice and correctional systems.

While this expenditure increase benefited selected CMH service providers, the majority received no additional money beyond a 1.5% annual increase in the last few years.

The Auditor recommended that the LHINs, in consultation with the Ministry of Health and Long-Term Care, provide the community capacity and resources needed to serve people with a serious mental illness being discharged from institutional settings.

Wage Disparities between Community and Institutional Sectors

During the public hearings, Members were interested in the different salary grids between mental health service providers working in the community and those in hospitals. One witness estimated that the wage difference between nurses working in the community versus hospital would range between 10 and 15 % (without benefits). When factoring in benefits, the compensation discrepancy is even greater. The underfunding leads to challenges in recruitment and retention of community-based staff, high employee turnover, reduction of service and volume level, and less continuity in case management. The witness is employed at an agency which received a 1.5 % increase over the past year—yet, the agency's collective agreement required an increase of 3.25 %. To maintain a balanced

budget, those underfunded agencies have to reduce the number of staff and the levels of service to clients.

The Standing Committee on Public Accounts recommends that:

6. **The Ministry of Health and Long-Term Care and the LHINs report to the Standing Committee indicating what is being done to alleviate the remuneration disparities between service providers working in the community mental health sector vis-à-vis their institutional counterparts.**

Historical and Needs-based funding

Review of Best Practices in Mental Health Reform, a federal document, states that the allocation of resources is more effective and equitable when it is based on actual needs rather than on historical funding. Needs-based funding directs resources to where the need is greatest, regardless of historical relationships with service providers and past patterns of funding use.

The Auditor noted that average per capita funding for community mental health services across the province was about $42. Yet historical-based funding has resulted in significant variation in regional average per capita funding—ranging from a high of $115 to a low of $19—depending upon where one lives in the province. These highly variable regional averages may not reflect current mental health needs.

Noting that people with similar needs should receive a similar level of community supports and services, the Auditor recommended that the Ministry and the LHINs collect complete data and cost estimates to review regional variations in population characteristics, needs, and health risks so that funding provided is commensurate with the demand for and value of the services to be provided.

During the hearings, Members asked the Ministry whether, at the time of transferring responsibility for community mental health to the LHINs, the Ministry intended to level the playing field and transfer services and resources to the LHINs that reflected the principle of equitable and uniform service levels and supports.

The Ministry responded that no such adjustment was made at the time of the transfer; it simply took existing agreements with its agencies and transferred them to the respective LHINs. In future the LHINs will determine what gaps or unmet needs exist, and how to fund them in future budget cycles.

Some Members would like the funding allocations to agencies made public to draw attention to those areas of the province that may be over-funded or under-funded, relative to its needs. Members expressed the view that the LHINs with heavier mental health caseloads should be allocated more resources based on their greater needs.

New Health-Based Funding Methodology

The Ministry is exploring a new funding model and management tool for health care in Ontario known as the Health-Based Allocation Model (HBAM). It is based on measures of health status and other population-based factors. HBAM will also be applied to the CMH sector. The pace of model development will depend upon such factors as data availability and quality. The Ministry estimated that the HBAM model for community mental health will be implemented within 24 months. Some Members expressed surprise that it would take as long as 24 months.

The Ministry explained that the new funding model requires data and information on the population and in some cases, the data is incomplete or unreliable. Once those shortcomings are addressed, the Ministry will test the model to ensure that it is a fair and accurate method of making the allocation.

The Ministry is concerned about the adequacy of information provided by a large number of agents—with 330 community health agencies and several public hospitals. There is also the challenge of making sure that the funding model actually works. In the meantime, while the new funding model is under development, the Ministry through the LHINs will continue to allocate resources to CMH providers.

The prospect of allocating funding to the 330 or more providers in the community mental health sector raises a number of key questions. Members wondered whether the LHINs and the Ministry have a good grasp of all these disparate agencies, of which some have operated with considerable autonomy. Members also wondered what is known about the providers. Is information available on their services? Are the services being delivered, and are they effective? Is the province receiving good value for the funding it provides to them?[7]

The Standing Committee on Public Accounts recommends that:

7. **The Ministry of Health and Long-Term Care report to the Standing Committee to clarify how the Health-Based Allocation Model (HBAM) will redress the issue of historical-based funding in this sector which has led to regional disparities in program funding. The report should also indicate when the Ministry expects HBAM to be implemented as the primary basis for funding community mental health services across the province. Finally, the report should indicate whether the Ministry and the LHINs agree with the position of the**

[7] Standing Committee Members heard about a similar subject matter during the hearings held on Child and Youth Mental Health (Sec. 3.04 of the Auditor's *2008 Annual Report*). There, a witness pointed out that about 100 agencies form the backbone of the community-based children's mental health covering the province. He described these agencies as the locus of clinical and research expertise on the delivery of child and youth mental health services. Yet, there are approximately 440 transfer payment agents in this program and the witness is unable to identify approximately 300 of them. See Ontario, Legislative Assembly, Standing Committee on Public Accounts, *Hansard: Official Report of Debates*, 39th Parliament, First Session (29 April, 2009): pp. 346-7.

Standing Committee, namely—that service agreements between the LHINs and all its provider agencies in this sector should be signed before funds begin to flow under the new HBAM funding formula.

8. **The Ministry of Health and Long-Term Care in cooperation with the LHINs, should report to the Standing Committee indicating whether it has a satisfactory understanding of the specific services being provided by each of the approximately 330 service providers in the community mental health sector.**

Housing

Homelessness is a common experience of those who suffer from an SMI. On average, 30 to 35% of homeless people have mental health problems. Housing, a key determinant of health, plays a critical role in an effective CMH system. When clients with mental illness have choice and control over their housing, they tend to report increased well-being. Supportive housing offers individualized, flexible, and rehabilitation-oriented supports to help clients improve their community-living skills and maximize their independence.

The Ministry remains the sole provincial funder for both the support services and the accommodation components of supportive housing. Almost 8,000 mental-health supportive housing units, managed by 86 housing providers, were available in Ontario at the time of the audit. These included about 3,300 "dedicated" units purchased by housing providers with government funds and operated by not-for-profit housing providers; and 4,600 "rent supplement" units – secured by housing providers from private landlords. The Ministry pays a rent subsidy to the housing provider to assist with clients' monthly rental payments.

Supportive Housing Shortages

A critical shortage of supportive housing units exists in Ontario with waiting time ranging from one to six years. An uneven distribution of units is also prevalent throughout the province, ranging from 20 units per 100,000 people in one LHIN to 273 units per 100,000 people in another. On the other hand, some service providers in the Greater Toronto Area (GTA) had vacancy rates as high as 26 % while other regions experienced serious shortages.

The Auditor recommended that the Ministry and the LHINs tackle several areas with regard to supportive housing. First, improve data collection and system monitoring to determine the number and type of housing units needed; the areas experiencing serious shortages of such housing; the levels of unmet needs, occupancy and vacancy; and, the adequacy and appropriateness of care provided to housing clients. Secondly, the Ministry and the LHINs should ensure that one-time capital funding is being spent in a timely and prudent manner.

During the public hearings, one of the witnesses expressed the view that the CMH system desperately needs affordable, safe, supportive housing. Many with severe mental illness are residing in the shelter system, jails, or in acute care hospitals for

long lengths of stay. The witness pointed out that "although the Ministry of Health and Long-Term Care has been very good about providing investments in this area, the under-resourcing at the community is by more than 100%." The current demand is great and far outweighs the supply.

The Ministry informed the Committee that over the past four years, the province has added a total of 2,250 new supportive housing units, with a budget of approximately $36.5 million allocated among 14 LHINs. The Ministry has responsibility for about 12,500 beds. Of that supply, about 8,500 are occupied by persons suffering from mental illness. The Ministry also operates nearly 1,000 homes with special care beds. It is planning to add an additional 1,000 supportive housing beds over the next couple of years.

Several witnesses emphasized the *support* in supportive housing, viewing such housing as a key investment that goes a long way to address severe and persistent mental illness and homelessness. In their view, housing is simply not successful unless there are ongoing mental health supports.

The Standing Committee on Public Accounts recommends that:

9. **The Ministry of Health and Long-Term Care and the LHINs report to the Standing Committee indicating what resources or tools they need to assess the overwhelming demand for supportive housing in the community mental health sector. The report should also indicate what is being done to manage the demand, and whether the Ministry shares the Committee's view that when allocating new supportive housing, the Ministry should look at the LHINs with the greatest needs.**

Program Standards

Many Community Mental Health Programs Lack Standards

As the number of people who receive mental health services in the community grows, it is important to have measurable and meaningful program standards to ensure that clients' needs are met. Without standards and criteria, such as staff qualifications and staff-to-client ratios, it is difficult to assess whether the SMI are receiving the level and quality of services required.

Similar to the 2002 audit, the 2008 audit found that the Ministry still lacks standards defining acceptable services and quality for most funded CMH programs. For example, three programs—short-term crisis residential beds, community treatment orders, and early intervention in psychosis program—which served about 10,000 clients across Ontario in 2006/07, all lack provincial standards.

While the Ministry does have provincial standards for ACT Teams, intensive case management, and crisis intervention, the Auditor noted that neither the Ministry nor the LHINs were monitoring the service levels against the standards. Some

service providers reported that in the past five years, no Ministry or LHIN staff had contacted them. Although ACT Teams did have standards, the average caseload fell below the targeted caseload. Issues also arose over the accuracy and reliability of the Teams' data, making it difficult to measure the performance of each ACT Team against the standards.

The Auditor recommended that the Ministry and the LHINs establish provincial standards, performance benchmarks, and outcome measures for the more critical programs against which the quality and costs of services can be evaluated. The Ministry and the LHINs should also improve data-collection and reporting to obtain relevant, accurate, and consistent information across Ontario for performance monitoring purposes.

During the hearings, the Ministry noted that its overall role and responsibilities include setting provincial policy and program standards. The Committee asked the Ministry about the status of provincial standards for the CMH sector. Specifically, what provincial standards "framework" did the Ministry expect the LHINs to utilize when responsibility for the sector was transferred to them? In response, the Ministry noted that its development of provincial standards in this sector is largely a "work in progress" due to various factors identified elsewhere in the Auditor's report—the nuances and complexity of the community mental health delivery system, weaknesses pertaining to data collection, data quality, and information reporting, including lack of automation among smaller providers in some cases. The Ministry recognizes that establishing provincial policy and program standards is a huge, challenging undertaking for the Ministry, the LHINs, and service providers. But the Ministry also recognizes that it is an area that needs to be addressed.

The Committee asked witnesses about the performance and monitoring of ACT Teams, one of the few CMH programs with provincial standards.[8] The Committee heard that the Teams, though resource-intensive, help maintain clients in their home communities instead of hospitals. Though well-regarded, the Teams often had long wait times ranging from eight months to a year. Increased CMH funding in recent years has established an additional 20 ACT Teams in Ontario.

The Committee highlighted a finding by the Auditor in the 2008 audit. The average caseload for ACT Teams was 63, well below the targeted caseload of 80-100 clients. The Ministry indicated that some teams were performing below the target caseload because they were new. In addition to raising the performance levels of the Teams, the Ministry pledged to improve the accuracy and reliability of Teams' reporting, as suggested by the Auditor.

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[8] Assertive Community Treatment (ACT) Teams are an alternative to hospitalization for the seriously mentally ill. They provide ongoing, individualized intensive support, helping clients develop the skills they need to live in the community. Each multidisciplinary ACT Team provides a full range of services to a roster of between 80 to 100 clients. Each team consists of nine to 12 full-time clinical staff including a psychiatrist, nursing staff, a program assistant and team coordinator, among others. Services are available 24/7. Ontario, Office of the Auditor General, *2008 Annual Report* (Toronto: The Office, December 2008), p. 191.

The Committee believes that by tackling the lack of program standards in several community mental health programs, the Ministry will also discover that it is addressing a number of other gaps and shortcomings in this sector.

The Standing Committee on Public Accounts recommends that:

10. The Ministry of Health and Long-Term Care, in collaboration with the LHINs report to the Standing Committee indicating what major steps are involved in developing standards for all the community mental health programs that currently lack them. The report should also indicate the sequence of the steps and the associated time frames for each.

Performance Measurement and Reporting

The Ministry's 1999 policy document, *Making it Happen* states that one of the goals of mental-health reform is to "achieve clear system service responsibility and accountability through the development of explicit operational goals and performance indicators." Performance indicators, which are quantifiable measures, reflect the critical success factors of a program or service, providing a meaningful method for measuring and reporting on progress in achieving objectives.

Ministry Operational Goals and Performance Indicators

Making it Happen called for explicit operational goals and performance indicators. The Ministry's *2007 Mental Health Strategy Map and Mental Health System Scorecard* takes a step in that direction, but the Ministry and the LHINs still lack sufficient information to assess the adequacy of community-based care received by those with an SMI.[9] Among those indicators deemed ready for full implementation, the Ministry still has not developed measurable and meaningful targets or benchmarks for each, despite having identified this need in the earlier 1997 and 2002 *Annual Reports*. The Ministry is aware that the lack of these benchmarks hampers its ability to measure and compare performance between service providers.

The Auditor recommended that the Ministry complete the implementation of its comprehensive set of performance indicators and select targets or benchmarks to enable the Ministry and LHINs to properly assess the performance of service providers. The Ministry should improve information systems to enable it to collect complete, accurate, and useful data for the process of making management decisions and determining service effectiveness. The Auditor also recommended that from time to time, the Ministry publicly report on the performance indicators for the CMH sector.

[9] As an element of performance measurement, the goals of the mental health strategy map are linked with the mental health scorecard's 29 indicators to enable the Ministry to determine what it needs to do to improve performance, achieve outcomes, and increase accountability. About half of the indicators are not yet ready for implementation due to lack of data sources or measurement challenges. See Auditor General's *2008 Annual Report*, p. 194.

During the public hearings, the Ministry spoke of its commitment to collect information about services and clients in this sector. Over the past five years, it has invested resources and funding to implement the Management Information System (MIS) and the Common Data Set for Mental Health (CDS-MH). The Ministry has successfully piloted and is considering implementing the community mental health common assessment tool which will help providers across the province to better understand and act upon the needs of clients. The Auditor's *Annual Report* noted that 80% to 90% of service providers are submitting data and complying with the reporting requirements, but more attention is needed in this area.

The Ministry recognizes that the quality of service providers' data needs to be improved, and it is working with the LHINs to determine how best to assist the providers to address this aspect of their operations.

The issue of data collection, data quality, and reporting arose frequently throughout the public hearings during Committee discussions on most topics—access to CMH services, funding, supportive housing, and provincial program standards. Discussions also suggested that these data-related issues were exacerbated by lack of oversight, monitoring, and timely feedback by staff of the Ministry or LHINs to service providers who, at times, lacked expertise, resources, clarity, and support. The Committee believes that the data issue is critical for CMH as only complete, accurate, and useful data can be used to measure and report on the effectiveness of services in this sector.

The Committee has no wish to create an onerous reporting burden on small community mental health providers. But it also recognizes that the LHINs and the Ministry do need information from these agencies for decision-making purposes.

The Standing Committee on Public Accounts recommends that:

11. **The Ministry of Health and Long-Term Care in cooperation with the LHINs report to the Standing Committee indicating how they are working to ensure that service providers in the community mental health sector gather complete, useful, and accurate data. The report should also indicate whether the Ministry or the LHINs review this information and provide timely feedback to the providers on any concerns.**

Monitoring and Accountability

As Crown corporations, the LHINs have responsibility for managing local health system service providers on behalf of the Ministry. Therefore, the Ministry must have appropriate monitoring mechanisms. Ultimately all system partners—the Ministry, the LHINs, and the CMH service providers, are accountable to Ontarians for meeting the needs of the mentally ill.

Service Accountability Agreements and Performance Schedules

Signed service agreements that stipulate reporting requirements and specific, measurable results are the primary method of holding service providers accountable. The existing agreements between the Ministry and service providers will continue until the LHINs negotiate new service accountability agreements with service providers. Negotiations for new agreements in this sector took place in the 2008/09 fiscal year with the agreements coming into effect April 1, 2009. These new agreements are to include performance schedules to allow the LHINs to measure performance expectations of the service providers. At the time of the audit, however, the agreements had not yet been finalized.

The Auditor recommended that the Ministry develop compliance mechanisms to monitor the LHINs' accomplishment of their stated priorities and to provide feedback to the LHINs for improvement of their operations. He further recommended that the LHINs develop guidelines together with the Ministry for monitoring service providers.

During the public hearings, the Ministry and the LHINs clarified their accountability relationship to each other and with the sector's service providers. The Ministry has accountability agreements with each of the 14 LHINs. The LHIN-Ministry accountability agreements set out the government's expectations and specify a level of expenditure transfer to the LHIN for CMH services and a specified set of operating guidelines.

The LHINs are responsible for planning, funding, integrating, and exercising oversight over CMH service providers. The Ministry works closely with the LHINs to identify and address service gaps. When the Ministry transferred responsibility for community mental health to the LHINs in April 2007, the service agreements that existed between the Ministry and the service providers were transferred to the LHINs. From that point onward, the LHINs became responsible for negotiating new agreements with the service providers. The Committee heard that the LHINs are in the process of establishing new accountability agreements with over 300 CMH service providers using a common template. The LHINs expected to have them all signed by March 31, 2009 to start the next fiscal year.

Prior to the establishment of the LHINs, the CMH service providers "reported" to the Ministry's seven regional offices. During the hearings, the Ministry indicated that since the establishment of the LHINs, reporting by service providers continues to flow to the Ministry which in turn, forwards that information to the LHINs. This avoids the creation of "double reporting" processes, according to the Ministry.[10] The LHINs do, however, exercise influence over the service

[10] In response to a Member asking if the LHINs were going to collect information from agencies, the Deputy responded as follows: "[The LHINs] don't collect it directly. In all of our reporting since LHINs were put in place, we've tried not to duplicate reporting systems. So where there was provincial reporting and continues to be, or new information requirements, we continue to rely on the reporting from the agents through the normal ministry channels. Then the ministry presents the information back to local health integration networks, as opposed to creating double reporting

providers with respect to determining new reporting requirements. In such cases, the Ministry and/or the LHINs would work on these requirements by adjusting the accountability agreements between the LHINs and the service providers.

The Ministry describes the reporting relationship between itself, the community mental health service providers, and the LHINs, as one where the service providers report to the Ministry rather than to the LHINs. This reporting relationship appears to contradict the opening remarks of the Deputy Minister who declared that "today, community mental health agencies report through the LHINs."[11] The Committee seeks clarification from the Ministry.

The Standing Committee on Public Accounts recommends that:

12. **The Ministry of Health and Long-Term Care, in cooperation with the LHINs, report to the Standing Committee clarifying the current reporting relationships among the community mental health service providers, the LHINs, and the Ministry. The report should indicate how the reporting would meet the information needs of each without imposing a significant burden on service providers.**

processes." See Ontario, Legislative Assembly, Standing Committee on Public Accounts, *Hansard: Official Report of Debates*, 29th Parliament, 1st Session (18 February 2009), p. 227.

[11] Ibid.

CONSOLIDATED LIST OF RECOMMENDATIONS

The Committee requests that the Ministry of Health and Long-Term Care provide the Committee Clerk with a written response to the following recommendations within 120 calendar days of the tabling of this report with the Speaker of the Legislative Assembly.

1. **The Ministry of Health and Long Term Care in consultation with the LHINs report to the Standing Committee confirming that they are developing provincial benchmarks such as wait times for community mental health services. The report should indicate the steps required and the time horizon for this initiative. Lastly, the report should indicate whether reporting of wait time targets is now (or will be) a component of the service accountability agreements between the LHINs and the community mental health service providers.**

2. **The Ministry of Health and Long-Term Care report to the Standing Committee (i) whether in its view the *Mental Health Act* can adequately meet the needs of those who seek appropriate services for seriously mentally ill persons who refuse treatment or who pose a danger to self and others; and (ii) whether the Ministry keeps statistics about the lack of appropriate services in such circumstances.**

3. **The Ministry of Health and Long-Term Care in consultation with the Ministry of Community and Social Services report to the Standing Committee providing a status report on the new joint policy guideline for provision of community mental health and developmental services for adults with a dual diagnosis. Specifically, the Committee is interested in knowing:**

   - **how well the new guideline is working in the field to assist service providers in helping those with a developmental disability who have mental health needs;**
   - **whether the Ministries of Health and Long-Term Care and Community and Social Services are clear as to their respective responsibilities and are successfully coordinating their services to serve these individuals; and**
   - **at what point will the effectiveness of the joint guidelines be assessed by the two ministries.**

4. **The LHINs should report to the Standing Committee on how they plan to achieve integrated mental health services. The report should address transitions between all the players in the system; whether they have considered establishing a single point of entry for people seeking access; and if so, an estimate of the timeframe involved.**

5. **The Ministry of Health and Long-Term Care should consult with the Ministry of Community Safety and Correctional Services (MCSCS) and report back to the Standing Committee as to the following:**

   - **whether MCSCS gathers statistics from local police services, (including the Ontario Provincial Police) that keep track of trends concerning interactions between the police and mentally ill persons in crisis situations; and**
   - **what kind of training is available to help police learn how to interact skilfully and professionally in all situations involving serious mentally ill persons in the community.**

6. **The Ministry of Health and Long-Term Care and the LHINs report to the Standing Committee indicating what is being done to alleviate the remuneration disparities between service providers working in the community mental health sector vis-à-vis their institutional counterparts.**

7. **The Ministry of Health and Long-Term Care report to the Standing Committee to clarify how the Health-Based Allocation Model (HBAM) will redress the issue of historical-based funding in this sector which has led to regional disparities in program funding. The report should also indicate when the Ministry expects HBAM to be implemented as the primary basis for funding community mental health services across the province. Finally, the report should indicate whether the Ministry and the LHINs agree with the position of the Standing Committee, namely—that service agreements between the LHINs and all its provider agencies in this sector should be signed before funds begin to flow under the new HBAM funding formula.**

8. **The Ministry of Health and Long-Term Care in cooperation with the LHINs, should report to the Standing Committee indicating whether it has a satisfactory understanding of the specific services being provided by each of the approximately 330 service providers in the community mental health sector.**

9. **The Ministry of Health and Long-Term Care and the LHINs report to the Standing Committee indicating what resources or tools they need to assess the overwhelming demand for supportive housing in the community mental health sector. The report should also indicate what is being done to manage the demand, and whether the Ministry shares the Committee's view that when allocating new supportive housing, the Ministry should look at the LHINs with the greatest needs.**

10. **The Ministry of Health and Long-Term Care, in collaboration with the LHINs report to the Standing Committee indicating what major steps are involved in developing standards for all the community**

mental health programs that currently lack them. The report should also indicate the sequence of the steps and the associated time frames for each.

11. **The Ministry of Health and Long-Term Care in cooperation with the LHINs report to the Standing Committee indicating how they are working to ensure that service providers in the community mental health sector gather complete, useful, and accurate data. The report should also indicate whether the Ministry or the LHINs review this information and provide timely feedback to the providers on any concerns.**

12. **The Ministry of Health and Long-Term Care, in cooperation with the LHINs, report to the Standing Committee clarifying the current reporting relationships among the community mental health service providers, the LHINs, and the Ministry. The report should indicate how the reporting would meet the information needs of each without imposing a significant burden on service providers.**