

3.03–Community Mental Health

BACKGROUND

In 1976, the Ministry of Health and Long-Term Care began funding community-based mental health services to address a growing need for community-based services. Transfer payments are provided to community agencies or general hospitals through the Ministry's Integrated Health Care Program to deliver community-based mental health programs and to help cover the costs for sessional fees, homes for special care, and other housing with supports. The types of programs and services funded include assertive community treatment teams, housing, social rehabilitation, vocational assistance, case management, crisis response, day treatment programs, court diversion, clinics, self-help and prevention. These programs are primarily designed to meet the needs of the seriously mentally ill who are 16 years and over.

The *Ministry of Health Act*, the *Mental Health Act*, the *Substitute Decisions Act*, the *Health Care Consent Act* and the *Homes for Special Care Act* all govern certain aspects of the community mental health programs funded by the Ministry. In 1999, the Ministry released *Making It Happen*, outlining the Ministry's three-year strategy for restructuring the mental health system "to support much needed changes in the way services are delivered."

According to the Ministry, "one of the goals of mental health reform is to create local systems of care that will ensure access to a broad range of community-based services and support, and provide choices for people with mental illness. These local systems of care will enable them to set and realize their personal goals, and acquire the skills and resources needed to achieve independence and well being."

Making It Happen (1999) identifies people with serious mental illness as the priority for community mental health services. According to the Ministry, "the critical dimension is the extent of disability and serious risk of harm to themselves or others related to a diagnosable disorder." At the time of our audit, the Ministry estimated that approximately 2.5% of the population of Ontario, or 300,000 people, are seriously mentally ill.

In December 2000, "Brian's Law" amended the *Mental Health Act* and the *Health Care Consent Act*. The amendments expand the assessment and committal criteria to include

chronically mentally ill persons and allow their families and health professionals to intervene at an earlier stage in the committal process.

During the 2001/02 fiscal year, the Ministry provided approximately \$390 million in transfer payments for community-based mental health services.

AUDIT OBJECTIVES AND SCOPE

The objectives of our audit of community mental health were to assess whether:

- the Ministry had defined its expectations for community mental health and whether adequate procedures were in place to ensure services funded by the Ministry were meeting those expectations; and
- resources were acquired and managed with due regard for economy and efficiency.

In conducting our audit, we reviewed relevant files and administrative policies and procedures and interviewed staff at the Ministry's head office and three of its seven regional offices. We also visited a number of community mental health agencies to gain a better understanding of the services being provided and relevant procedures and to corroborate information provided to us by the Ministry.

Our audit was conducted in accordance with the standards for assurance engagements, encompassing value for money and compliance, established by the Canadian Institute of Chartered Accountants and accordingly included such tests and other procedures as we considered necessary in the circumstances. Prior to the commencement of our audit, we identified the audit criteria that would be used to address our audit objectives. These criteria were discussed with and agreed to by senior ministry management and relate to systems, policies, and procedures that the Ministry should have in place.

Our audit was substantially completed in April 2002. We did not rely on the Ministry's internal audit branch to reduce the extent of our audit work because they had not recently conducted any audit work on community mental health services that impacted on our audit.

OVERALL AUDIT CONCLUSIONS

Since 1988, the Ministry has conducted numerous studies on the future direction of Ontario's mental health system. Since 1993, the primary focus has been on the needs of people with serious mental illnesses. The Ministry's strategy document, *Making It Happen* (1999), outlines the characteristics of the reformed mental health system, implementation priorities, core service requirements and definitions, as well as functional descriptions of specific program models.

Many of the fundamental issues and concerns identified in our audits over the last 15 years have not been comprehensively addressed. In particular, we found that, except in the case of assertive community treatment teams, the Ministry still had not clearly defined its expectations for community mental health and did not have sufficient information to enable it to assess whether mentally ill people were being adequately cared for and whether funding provided for community-based mental health services by the Ministry was being prudently spent. Specifically, we noted that:

- The Ministry generally did not have standards and performance measures for community mental health and had only limited information about whether community mental health resources were being utilized efficiently and effectively.
- The Ministry did not have adequate information on the number of people receiving or waiting for community mental health services or on the waiting times to access services, which limited its ability to assess whether sufficient and appropriate services were available to meet the needs of seriously mentally ill individuals.
- In many areas of the province there is still no comprehensive source of information about available mental health services or how to access those services. In addition, there is minimal co-ordination among agencies providing services.
- The Ministry had not determined the number or type of housing spaces required to meet the needs of seriously mentally ill individuals or whether existing housing was meeting the needs of the individuals housed.
- The Ministry had not determined the number and locations of assertive community treatment teams needed to provide adequate support services to individuals with serious and persistent mental health problems and the level of less intensive services needed to meet the needs of individuals who no longer require assertive community treatment.

With respect to acquiring and managing resources with due regard for economy and efficiency, the Ministry had not given sufficient consideration to the funding of community mental health agencies based on an assessment of the number of patients requiring services and the complexity of patients' needs. In particular:

- Annual per capita funding in the seven regions of the province ranged from approximately \$11 to \$60; however, the Ministry had not analyzed whether the significant variation in per capita funding is resulting in different levels of service for individuals with similar needs depending on where in Ontario they live.
- Since 1992, there have been no increases in base funding provided to community mental health agencies for programs that were operating at that time. One district health council noted that this has forced community mental health agencies "to reduce services to the seriously mentally ill in order to stay within existing base budgets."

We also concluded that, to provide better accountability to the public and the Legislature, the Ministry needed to develop results-oriented performance measures and periodically

report publicly on the performance of community-based mental health services in meeting the needs of the mentally ill.

DETAILED AUDIT OBSERVATIONS

MENTAL HEALTH REFORM

Mental illness can result in serious disability, hospitalization, suicide, and risks to public safety. A 1996 study projected that, in developed countries of the world, the burden of mental illness would grow and that depressive illness would become the leading cause of disability.

Over the past 14 years, there have been a number of ministry policy and implementation strategies to reform Ontario's mental health system, including *Building Community Support for People: A Plan for Mental Health in Ontario* in 1988, *Putting People First* in 1993, and *Making It Happen* in 1999.

In *Putting People First* (1993), the Ministry announced a 10-year strategy, commencing in 1993, for reforming the province's mental health system, noting that if community services were effective in providing care in the community, the hospitalization rate for people with mental illnesses should drop. Along with the strategy, the Ministry established measurable targets and timelines for the number of beds and for funding. The target for number of beds was subsequently modified based on recommendations from the Health Services Restructuring Commission in a 1997 discussion paper and in its 1999 *Advice to the Minister of Health on Building a Community Mental Health System in Ontario*.

Status of Community Mental Health Targets for Spending and Number of Beds, 1997–2003

Target Area	Target for 2003	Status as of March 31, 2002	Status as of March 31, 1997
Ratio of community to institutional spending	60:40	46:54	32:68
Number of hospital psychiatric beds per 100,000 people	35 (ultimate target: 30)	41	43

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

The Commission noted that “the proposed hospital bed targets are achievable once the appropriate community services and supports are in place to reduce reliance on institutional care (especially provincial psychiatric hospitals) and dramatically reduce the need for hospital-based treatment services.” The Ministry informed us that it was still planning to

meet these targets as part of its “long-standing public strategy to reduce the number of beds—only after the establishment of appropriate community-based services.”

In *Making it Happen*, which is currently being used to provide implementation direction for mental health reform, the Ministry indicates that the key characteristics of a reformed mental health system include a continuum of care, in which clients receive services when and where they need them. Other characteristics are streamlined access to mental health services and the provision of services based on best practices.

According to the Ministry’s implementation plan for *Making It Happen*, people with serious mental illnesses are the priority for mental health services. The implementation plan outlines the Ministry’s “strategy to increase the capacity of the system for comprehensive and integrated treatment, rehabilitative and support services, while focusing on community alternatives wherever possible.” In addition, the plan states that in the year 2002, the Ministry is to review and revise implementation strategies and program funding priorities as necessary. The Ministry advised us that the evaluation will begin during the 2002/03 fiscal year.

Commencing in May 1999, as recommended by the Health Services Restructuring Commission, the Ministry established nine regional Mental Health Implementation Task Forces. The task forces were appointed by the then Minister and include representatives from psychiatric hospitals, general hospitals, and community mental health agencies, as well as general members from communities across the province and consumer and family representatives. The task forces, which are expected to complete their work by December 2002, were asked to look at options to:

- provide a greater range of services in the community;
- improve access to mental health services;
- tailor services to those with mental health needs;
- link services so those with mental illness can move seamlessly within the system; and
- ensure services are based on best practices.

In addition, in January 2001, a provincial forum comprised of the nine task force chairs was established to identify provincial issues that need to be addressed to successfully implement mental health reform across Ontario. The provincial forum reports to the Minister.

Our concern is that a number of the issues currently being addressed, such as the lack of community-based support services, were raised by us 15 years ago in our *1987 Annual Report* and that the mental health best practices that have been identified in the various policy and implementation strategies are still to be comprehensively implemented.

Recommendation

The Ministry should ensure that the necessary reforms, including best practices identified in the studies, are implemented as soon as possible in order to meet the needs of the seriously mentally ill.

Ministry Response

The Ontario government is committed to building an integrated system of mental health services based on best practices to meet the needs of persons with serious mental illnesses. Since 1995, the government has invested more than \$380 million in mental health care services.

In order to undertake the government's implementation strategy for mental health reform, as outlined in Making It Happen, the government established nine regional Mental Health Implementation Task Forces as well as a Provincial Forum of Chairs, whose reports are expected to be completed in December 2002. The Task Forces have been asked to develop regional implementation plans to operationalize a restructured local and regional mental health system. The Provincial Forum is also preparing provincial level recommendations.

ACCOUNTABILITY

Accountability Framework

According to the Management Board of Cabinet Directive on Transfer Payment Accountability, transfer payments should be managed wisely and prudently to achieve value for money. The directive lists accountability elements that should be in place, including: defined expectations that focus on measurable results; signed agreements that state recipient reporting requirements and bind recipients to achieve specific, measurable results; and ministry monitoring and corrective action in cases of recipient non-compliance with the agreement.

In our *1997 Annual Report*, we noted that the Ministry had recognized the need to strengthen its accountability relationship with community mental health agencies and had drafted a service agreement that required agencies to use ministry funding in accordance with approved operating plans and budgets. At that time, we were advised that these agreements were being put in place. During our current audit, we found that agreements with some assertive community treatment teams (discussed later in this report) had been signed, but the Ministry generally still did not have agreements signed with community mental health agencies. At the completion of our audit, transfer-payment agreements and operating manuals were being distributed to all mental health and addiction agencies. The Ministry indicated that it expects agreements to be finalized in fall 2002 and believes that this will go a long way in strengthening the accountability framework.

In *Making It Happen*, the Ministry states that it is “committed to the principle of greater accountability in the reformed mental health system. The mental health system will be measured against the accountability framework that is to be developed.” We were advised that developing a mental health accountability framework is one of the priority areas of the Mental Health Implementation Task Forces and that a Mental Health Accountability Framework Reference Group, comprising ministry and external representatives, was established in the latter part of the 2001/02 fiscal year to provide advice to the Ministry on developing such a framework. Ministry staff also indicated that they were proceeding with the development of a provincial accountability framework for mental health services. In that regard, the Reference Group had prepared a summary of accountability approaches and strategies in other jurisdictions.

Recommendation

To better hold community mental health agencies accountable for the services provided and for the prudent management of the funds they receive, the Ministry should ensure that all basic elements of the Management Board of Cabinet Directive on Transfer Payment Accountability are addressed, including signed agreements that require recipients to achieve specific, measurable results.

Ministry Response

The Ministry has now developed a mental health accountability strategy that consists of four elements:

- ***an accountability framework that outlines goals, purposes, performance domains, and indicators: in addition, performance measures based on the domains and indicators, as well as data collection tools, are being developed by the Ministry’s Health Care Programs Division;***
- ***legal agreements between the Ministry and transfer-payment recipient agencies;***
- ***a revised operating manual for mental health and addiction agencies; and***
- ***hospital accountability mechanisms.***

A service agreement has now been developed and sent to all community mental health agencies for signature. An initial program manual has also been issued. A working group is in place to develop the basic framework for specifying program expectations (that is, service units, client groups, and the key indicators to measure performance). This will evolve into schedules for the service agreements.

Performance Measurement and Reporting

Effective accountability requires that program clients, their families, the Legislature, and the general public be provided with timely, reliable information about the performance of community mental health programs. Performance information is needed to enable the Ministry to evaluate the impact of mental health reform, including the impact of changes in the structure and the organization of services. For example, performance information is needed to measure the extent to which mental health reform is improving the quality of life of community mental health clients and their families.

In our *1997 Annual Report*, we recommended that the Ministry establish performance benchmarks and outcome measures and monitor community mental health programs against them. This would help ensure that agreed-upon community-based services are being provided and that funding is reasonable and consistent. At that time, the Ministry indicated that mental health benchmarks, targets, and outcome measures were being developed and that the efficiency and effectiveness of service delivery would be the focus of further outcome measures that would span both the hospital and community sectors.

During our current audit, we found that, overall, the Ministry had limited information about whether community mental health resources were used efficiently and effectively and that the Ministry was still identifying performance indicators for mental health services. In addition, while performance measures for employment services and supports had been developed, they had not yet been fully implemented. As the Ministry noted in the terms of reference of the Mental Health Accountability Reference Group, various provincial data collection tools, evaluation and monitoring mechanisms, and performance indicators have been developed over the past several years. However, these are not being used consistently.

Many other jurisdictions are developing and implementing performance measures for mental health that address performance at system-wide, program, and client levels. Key measures assess outcomes such as improvement in clients' mental health status, clients' ability to function in society, and client satisfaction. Although outcomes may be affected by factors unrelated to an agency's services—for example, the severity of an individual's mental illness—outcome information can assist in improving program quality and the Ministry's ability to assess the cost effectiveness of programs.

We found that many jurisdictions in North America were already reporting publicly on the performance and outcomes of their community mental health systems. However, Ontario had not issued public performance reports for community mental health that included information on the Ministry's progress in meeting mental health reform targets.

Recommendation

To help achieve ongoing improvements in providing community mental health services, the Ministry should:

- develop and implement appropriate performance measures that objectively measure the success of agencies in meeting the needs of the seriously mentally ill;
- regularly report publicly on performance, including reporting on the impact of mental health reform; and
- take corrective action where required.

Ministry Response

The Integrated Health and Planning Division has now developed an accountability framework identifying key domains, and the Mental Health Accountability Reference Group will seek to identify indicators on which to report performance in those domains. The service agreement specifies reporting types and the timetable. Regional offices use a risk-based monitoring process to determine when and what corrective action is required.

Resources for hardware and software will be required for the planned information-system design.

Monitoring Community Mental Health Agencies

At the time of our current audit, there were approximately 370 community mental health agencies receiving ministry funding to provide mental health services and supports such as assertive community treatment, case management, crisis intervention, housing, consumer and family self-help, and vocational rehabilitation.

Community mental health agencies must submit annual operating plans, including program budgets, to their regional ministry offices and local district health councils. District health councils review the operating plans and provide comments to the Ministry if there are significant program changes. The review and approval of operating plans by the Ministry is to be completed by early June of each year, taking into consideration any comments from district health councils.

For the 2001/02 fiscal year, each community mental health agency's annual operating plan was required to include: a proposed budget with explanations of any significant changes from the prior year; program and client goals and objectives for the upcoming year; and a report on the agency's achievement of the goals and objectives established in the prior year's operating plan.

We found that the operating plans for the 2001/02 fiscal year were generally received and approved by the Ministry within a reasonable time frame. All three regions we visited used checklists to ensure that information was submitted in accordance with ministry requirements. However, since the process was done manually rather than electronically, no aggregate data on the agencies was available.

We reviewed a sample of 2001/02 operating plans at the three regions we visited and noted that they generally included a budget with explanations of any significant changes from the prior year, client goals and objectives for the upcoming year, and the agency's achievement of goals and objectives related to the prior year's operating plan. However, we also noted that, while agencies are required to report in their annual operating plans the number of individuals served by each type of service, they are not required to report the total number of individuals served or the number of seriously mentally ill individuals served. Without such information, the Ministry is hampered in its ability to make planning and funding decisions.

Prior to 1996 the Ministry conducted detailed reviews of community mental health agencies, in which it assessed basic aspects of program organization and delivery, including whether appropriate individuals received services and whether treatment goals for individuals were established and monitored. Since 1996, the Ministry has monitored agencies primarily through reviews of operating plans, informal visits to agencies, and telephone contacts. However, this process does not provide the information on the individuals served nor the assurance of the quality of the services provided that would be obtained from a detailed review.

Program standards establish performance expectations. For example, quality improvement standards would enable the Ministry to evaluate an agency's procedures for assessing and improving the quality of services it provides. We noted that, except for assertive community treatment teams (which are covered later in this report), the Ministry had not established standards for community mental health programs. Other jurisdictions in North America have established standards for community mental health programs such as supported housing and employment services.

A properly designed information system that includes the data required for appropriate performance measures is essential for the Ministry to identify agencies that require further review and would enable the Ministry to utilize its resources more efficiently.

Recommendation

To help ensure that resources are utilized efficiently and are achieving their intended results, the Ministry should:

- **ensure that it has adequate information to make planning and funding decisions; and**
- **require that agencies submit information on the number of seriously mentally ill individuals who received their services.**

To help ensure that community mental health agencies provide high quality programs, the Ministry should:

- **establish standards against which programs can be evaluated; and**
- **implement agency reviews focusing on those agencies identified as high risk.**

Ministry Response

Conversion of the existing Community Mental Health (CMH) Budget & Inventory System to a CMH MIS (Management Information System) chart of accounts in the Ontario Hospital Reporting System will provide the Ministry with more details for in-year reporting using standard financial and statistical accounts and consistent definitions of mental health services. This will allow the comparison of expenditures across and within the various mental health sectors.

Data collected by the Common Data Set—Mental Health, which employs the same set of mental health services that are defined in the CMH MIS chart of accounts, will capture additional clinical details to allow the Ministry to have information regarding services provided by the community mental health agencies to seriously mentally ill individuals.

The Mental Health Accountability Framework includes performance domains and indicators, which are based on the goals and principles set out in Making It Happen. Performance measures for each indicator are under development. Standards and benchmarks, based on best practices, are also under development.

Ministry regional offices will continue to undertake or contract agency reviews in response to program or financial concerns.

ACCESS TO COMMUNITY MENTAL HEALTH SERVICES

In *Making It Happen*, the Ministry states that “access to mental health services in Ontario can be confusing and time-consuming for clients and their families/key supports.” In that regard, we noted that in many areas of the province there is no central source of information about available mental health services or how to access these services. According to *Making It Happen*, in some areas of the province there is minimal co-ordination among agencies that provide similar or identical services, and individuals “are often unclear as to which services are suitable to their needs and how to access them. As a result, they may seek several services at once (undergoing separate assessments for each service) and they may be on several waiting lists at the same time.”

To reduce duplication, the Ministry funded a project to co-ordinate access to housing in Toronto. In March 2002, the “Report on the Planning and Development of a Coordinated Access System for Mental Health Supportive Housing in Toronto” was submitted to the Ministry, proposing a single housing application form. At the time of our audit, a budget detailing the cost of implementing this system was still to be prepared by the agencies involved with the project. The Ministry is also funding a project to develop a co-ordinated housing access system in another area of the province.

Community mental health agencies generally have their own access and exclusion criteria. For example, to access services, we found that some agencies required individuals to be diagnosed with a serious mental illness while other agencies did not. This creates a risk that some agencies may exclude individuals requiring more services. In addition, because agencies generally have their own intake and assessment processes, individuals apply separately to each agency to access services. This results in an inefficient use of agency staff and can be frustrating to individuals seeking assistance.

In February 2002, the Ministry issued “A Guide to Developing Recommendations on Streamlining Access to Mental Health Services and Supports.” According to the Ministry, this guide is intended to assist the Mental Health Implementation Task Forces, regional offices, and stakeholders to provide optimum services to clients and to minimize the duplication of services and maximize efficiency.

We were advised that the Ministry had no information available on the overall number of seriously mentally ill people waiting for services or the overall waiting times to access services provided by community mental health agencies. We also noted that agencies generally did not record waiting lists in a consistent manner, and waiting lists were not co-ordinated among different agencies. For example, some agencies limited the number of people that could be on their waiting lists, and others did not. Information on waiting lists and waiting times is needed by the Ministry to help determine the need for specific types of services.

Information about the mental health of people living in different regions of Ontario and the prevalence of specific mental disorders in those regions is important for helping to determine the need for services and for assessing the effectiveness of services provided. For example, the Ministry would be better able to identify and address service gaps if it had information about the number of seriously mentally ill individuals in a region. The information would assist in the effective planning, evaluation, and funding of community mental health services.

Over the past two years, community comprehensive-assessment projects were undertaken throughout the province to identify the care needs of clients in community mental health programs. These projects compared client needs with the care being provided.

The project reports that we reviewed stated that the needs of individuals were often either not sufficiently met or more than sufficiently met. One report noted that its results reinforced the importance of clearly defining program admission criteria, conducting ongoing utilization reviews to ensure that changing levels of need are identified and addressed, and reviewing the complement of program types required to meet client needs. However, the projects did not recommend the level of services needed to meet client needs and did not assess the needs of persons with mental health problems who currently were not using the mental health system. We were advised that the Ministry was in the process of analyzing the results of the projects.

The most recent data that the Ministry has on the prevalence of mental disorders is from the 1990/91 Mental Health Supplement to the Ontario Health Survey. While this survey

provided valuable information, only limited information was available regarding the seriously mentally ill and the severity and level of disability caused by some mental disorders. It also did not provide information concerning individuals who may have significant needs for services, such as individuals with psychotic disorders, including schizophrenia. Ministry staff informed us that a survey similar to the 1991 Ontario Health Survey was being conducted and that the results were expected in 2003.

In *Making It Happen*, the Ministry stated that “Clients, families/key supports and service providers will be able to contact a central source to get information about mental health services and how to access them.” In 2001, the Ministry provided funding to the Ontario Drug and Alcohol Registry of Treatment (DART) to develop a plan for a provincial registry of mental health services and an information line. DART is currently “a province-wide information and referral service available to service providers and members of the general public, including substance abusers and family/friends of substance abusers.” In May 2002, DART submitted a proposal to the Ministry for funding to develop and implement the mental health services registry. According to the proposal, the registry would support the development of two mechanisms identified in *Making It Happen* (1999): streamlined access for clients and families; and service/system accountability. At the conclusion of our audit fieldwork, the Ministry had not yet made a decision on whether to proceed with this initiative.

Recommendation

To help ensure timely and equitable access to services, the Ministry should:

- review the feasibility of further co-ordinating access to services, including establishing common intake and assessment criteria;
- obtain and analyze overall waiting lists and waiting times to help determine the need for specific types of services; and
- ensure that public information on community mental health services and how to access those services is readily available.

Ministry Response

In February 2002, the Ministry released the document “A Guide to Developing Recommendations on Streamlining Access to Mental Health Services and Supports.” This document sets out four key features for streamlining access to mental health services, along with goals, key considerations, and required outcomes for each feature. The four features are: centralized information and referral functions; facilitating access to consultation services provided by psychiatrists; minimizing the number of assessments; and fewer points of entry to mental health services. The Mental Health Implementation Task Forces and other stakeholders are to use the guide to develop recommendations for streamlining access to mental health services. The Task Force’s final recommendations are expected in December 2002.

At the community mental health agency level, waiting lists should be client specific and shared among agencies. The Ministry is proposing an initiative for a client linkage system that will provide community mental health agencies with the ability to share waiting lists.

At the ministry level, waiting-time statistics should be aggregated to provide data on service type and volume demand so that waiting lists can be strategically managed. This data element will be added to the Community Mental Health Management Information System proposal.

The Ministry has supported the planning for the development of a provincial mental health information system, building upon the existing Drug and Alcohol Registry of Treatment. Steps are being taken to seek funds for the establishment of this information network.

INFORMATION SYSTEMS

To assist them in co-ordinating and improving care and services, community mental health agencies need up-to-date and accurate information about their clients. Such information enables an agency to respond promptly and appropriately to individual client needs. The Ministry also needs relevant information to effectively monitor the performance of agency programs and the mental health system as a whole and to assess the impact of mental health reform.

People with serious mental illnesses often need access to a broad range of services, such as assessment, treatment, housing with supports, and vocational assistance. Services are often provided by different local community mental health agencies, which may result in duplication of consumer information and a lack of co-ordination among local services. Individuals whose mental illness affects memory and thought processes are at a greater risk of losing or failing to make contact with the appropriate agencies. Co-ordination of mental health services helps ensure that people receive the services they need.

We noted that other jurisdictions had electronic client records that integrated information from a number of sources. For example, the National Health Service in England is implementing an integrated electronic mental health record. In addition, other jurisdictions are developing information systems to address the information needs of multiple users, including community agencies, government, and mentally ill individuals and their families. Confidentiality and security of mental health information is also addressed as part of these systems.

A key aspect of such systems is a minimum data set, which is a uniform set of data that enables the collection and exchange of information among different service providers. It provides information such as: the type and volume of services provided, who provides the services, who receives the services, and service outcomes. Specific service definitions that establish uniform descriptions of the services provided by community mental health

agencies are needed to develop a minimum data set, and such definitions enable meaningful comparisons to be made of the costs and outcomes of services among programs.

As far back as our *1987 Annual Report*, we reported that the Ministry lacked the information necessary to plan and assess the operations of community mental health programs. In response to a related recommendation in our *1997 Annual Report*, the Ministry indicated it would be developing a mental health minimum data set. During our current audit and 15 years after we first raised the issue, we found that Ontario still has no integrated client information system. We also found that there are no system-wide agreements concerning who may access client information or under what circumstances. In many instances information is still largely paper-based. Except in the case of assertive community treatment teams, which are discussed later in this report, the Ministry has not yet developed service definitions that would enable comparisons among programs. In addition, we were informed that, while the Ministry has developed a minimum data set, its implementation has been delayed.

Many seriously mentally ill individuals receive care from various health care organizations as well as community mental health agencies. In order to co-ordinate information from all these service providers, many jurisdictions use unique client identifiers as part of their mental health information systems. The unique client identifier enables agencies to access key client data while safeguarding privacy and confidentiality. A unique client identifier also enables an individual's records in one information system to be matched with those in another system for purposes of evaluation and planning. For example, information on individuals receiving services from mental health agencies who also receive other medical services or who are involved with the justice system would assist the Ministry in determining the effectiveness of mental health programs and the need for programs.

At the time of our audit, the Ministry was in the process of establishing performance measures for mental health services. An effective mental health information system would incorporate the information required for these performance measures and, at the community level, provide data to help minimize duplication of services and maximize efficiency.

Recommendation

To better support the provision and co-ordination of community mental health services, the Ministry should design, implement, and appropriately utilize a mental health information system that captures relevant service and client data.

Ministry Response

The development of the Common Data Set—Mental Health is nearing completion. Following consultation and implementation, the Ministry will have

basic but consistent data on the definition of services, the number of clients, and the types and amounts of services received by mental health clients.

The Ministry is also developing a proposal for a client linkage system. The system's aim is to ensure that community mental health services are integrated and co-ordinated in such a way that only the most appropriate services are provided, in the interests of clients' well-being and community mental health resource utilization.

HOUSING

In the various mental health reform initiatives that have been proposed by the Ministry, there is general agreement that, with appropriate support, most seriously mentally ill individuals can live in the community. Research indicates that the housing needs and preferences of people with severe mental illness vary considerably, and therefore varying types of housing alternatives are needed to meet the needs of these individuals. Housing options funded by the Ministry include:

- housing under the Mental Health Homelessness Initiative;
- supportive housing;
- homes for special care;
- approved homes; and
- Habitat Services.

Housing Needs

In *Making It Happen* (1999), the Ministry promotes establishing a comprehensive mental health housing framework. The framework includes increasing the availability and use of accommodation that is desired by seriously mentally ill individuals and providing support services tailored to these individuals' needs.

In our *1987 Annual Report*, we commented on the shortage of good-quality affordable housing for individuals discharged from psychiatric hospitals and noted that this was a major cause of relapse and re-admission into psychiatric hospitals. During this audit, we found that the Ministry still had not determined the number or types of housing spaces required to address the needs of seriously mentally ill individuals. To complicate matters, the Ministry did not have any current province-wide information on the number of seriously mentally ill individuals who were homeless or inadequately housed. However, in 2001, the Ministry asked district health councils to conduct local research on the housing situation of persons with serious mental illnesses. The Ministry indicated that the resulting reports were designed to provide factual data but not specific recommendations. Nevertheless, the

Ministry believes this research may provide additional data on the need for housing support for the seriously mentally ill.

According to a 2001 Canadian Mortgage and Housing Corporation survey, three major urban centers in Ontario had rental accommodation vacancy rates of less than 1.5%. In addition, some areas of the province had very long waiting lists for social housing. Ministry staff also believed there were long waiting lists for ministry-funded supportive housing and advised us that one consequence of the housing shortage was that some seriously mentally ill individuals may be living in poor-quality housing or in a highly structured setting not appropriate for the individual.

Homes for Persons with Special Needs is an initiative introduced by the government to consolidate the Ministry of Health and Long-Term Care's homes for special care, approved homes, and Habitat Services with the Ministry of Community and Social Services' domiciliary hostels. The stated objective of this initiative is to improve the delivery of care for people with similar special needs by establishing common levels of funding and consistent standards, including those for staffing, drug control systems, nutrition, cleanliness, and assistance with aspects of care. While such an initiative is encouraging, it has been 15 years since we first raised a concern about the housing needs of the seriously mentally ill.

Recommendation

To help address the long-standing problem of affordable and appropriate housing for the seriously mentally ill, the Ministry should:

- **assess the number and types of housing units needed in different areas of the province and whether ministry-funded housing is meeting the needs of individuals already housed; and**
- **take appropriate steps to address the assessed housing needs.**

Ministry Response

In 2001, district health councils (DHC), on behalf of the Ministry, conducted local research on the housing situations of persons with serious mental illnesses. The DHCs consulted with key stakeholders, particularly consumers of mental health services, their families, mental health agencies, and housing providers. The consultations assessed current mental health housing and related support service delivery.

The survey also included suggestions from stakeholders on how to improve housing support for persons with mental illnesses. The study results were provided to the Mental Health Implementation Task Forces to help them in developing local mental health housing plans.

Based on the Task Forces' recommended local mental health housing plans, the Ministry will put forward appropriate housing strategies as part of the business planning cycle.

Outcome measures relating to “housing meeting required needs” can be achieved through the psychosocial rehabilitation tool kit when fully implemented through an information system.

Mental Health Homelessness Initiative

The 1998 *Report of the Provincial Task Force on Homelessness* noted that perhaps as many as one-third of all homeless people suffer from a serious mental illness. In March 1999, the Ministry announced a provincial homelessness strategy that included providing housing and support services for people with serious mental illnesses. Phase I of the Mental Health Homelessness Initiative was to develop approximately 1,000 new housing spaces with support services for people with serious mental illnesses in Toronto, Hamilton, and Ottawa. Phase II of the initiative, which was announced in November 2000, was to provide at least 2,600 additional supportive housing units throughout the province for seriously mentally ill individuals who were homeless or at high risk of homelessness. Phase II units were to be created over a two-year period.

For both phases, non-profit agencies received funding from the Ministry to acquire the needed housing units by entering into leases with landlords and then subletting the units to individuals in the target group. However, where vacancy rates were low and affordable rental units were lacking, the Ministry provided funding to the agencies to purchase properties and, if necessary, to renovate them. Based on ministry information, by March 2002, 950 units had been secured through Phase I of the initiative and about 970 units had been secured through Phase II, of which about 80% were rental units and 20% had been purchased.

We were advised that transfer payment agreements will be used to formally establish the accountability relationship between the Ministry and the agencies providing the supports.

For leased units, the Ministry sets the rate paid by tenants and pays the agency the difference between what the tenant pays and the lease rate; it also receives occupancy information from the agencies. On the other hand, for properties that were purchased, at the time of our audit, agencies determined the amount they charged tenants. The rent charged to tenants is intended to cover the operating costs of the property. The Ministry does not formally require that agencies with purchased properties provide information about the number of units occupied by seriously mentally ill individuals. We also found no evidence that the Ministry reviews the rents charged.

We reviewed a sample of properties purchased under Phase II and found that, when purchased, some properties were already rented to tenants whose occupancy is protected under the *Tenant Protection Act*. Ministry management stated that these tenants would leave over time and that the accommodation would then become available to house the seriously mentally ill. In the interim, the agencies collect rent from the existing tenants. Thus, although the Ministry has provided funding to agencies to buy these properties, it does not

know when they will actually house seriously mentally ill individuals. At our request, ministry staff obtained information about Phase II purchased properties and found that about 90 units still had the existing tenants and accordingly were not available to provide housing for the seriously mentally ill.

To determine whether Phase I of the Mental Health Homelessness Initiative had met its objectives, the Ministry surveyed Phase I housing providers for the period from April 1, 2000 to March 31, 2001. The survey results provided the Ministry with a variety of data, including a profile of the individuals housed. The profile indicated that these individuals were seriously mentally ill and either homeless or at risk of being homeless. However, the Ministry did not verify if the information was accurate. The Phase I agencies we visited confirmed that individuals housed in facilities funded through Phase I of the homelessness initiative were homeless or at risk of being homeless but they stated that a formal diagnosis of a serious mental illness was not required when assessing eligibility for housing as it was not available at the time of the assessment.

The Ministry is also funding a two-year evaluation of Phase I to assess the achievement of certain outcomes for the individuals housed and the impact the initiative has had on the use of emergency shelters, hospitals, and forensic services. A final report is expected by March 31, 2003.

Recommendation

To help ensure that the Mental Health Homelessness Initiative is meeting its objectives of providing housing with supports to seriously mentally ill individuals, the Ministry should:

- establish a formal process to obtain information about occupancy in housing purchased with ministry assistance;
- establish accountability agreements with all agencies; and
- ensure that funding is only provided for properties that are able to provide housing and support services for people with serious mental illnesses.

Ministry Response

The Ministry now requires agencies that have purchased properties to complete a year-end form that collects unit activity (that is, occupancy/vacancy) on a monthly basis.

Security agreements that outline accountability as it relates to the purchased property will be signed for all purchased properties.

Service agreements relating to the support services provided in the purchased properties under this initiative are in the process of being signed with the agencies.

All properties will be providing housing and support services for persons with serious mental illnesses. In cases of tenanted buildings, this will occur over time.

Supportive Housing

Supportive housing is non-profit, subsidized housing that includes support services such as case management, social rehabilitation, assertive community treatment, and, to some extent, crisis intervention. Effective April 1, 1999, the province transferred responsibility for approximately 3,100 supportive housing units from the Ministry of Municipal Affairs and Housing to the Ministry of Health and Long-Term Care. For the 2001/02 fiscal year, expenditures for these housing units were budgeted at \$26.5 million. About 75% of the housing units were for mentally ill individuals, while the rest serve long-term care or substance-abuse clients.

Agencies responsible for supportive housing units were generally required to have operating agreements with the Ministry detailing the respective responsibilities of the agencies and the Ministry. Ministry management informed us that, while there were no operating agreements covering some supportive housing projects, future planning for the entire supportive housing portfolio would include a review of operating agreements, and potential reform and consolidation of housing programs.

Since 1993, the main priority for mental health services has been the seriously mentally ill. However, at the time of our audit, the Ministry did not have any system-wide information about the individuals being housed in supportive housing units, or how many units were allocated to the seriously mentally ill. Without this information, the Ministry is unable to assess the extent current housing actually targets and serves the seriously mentally ill.

We selected a sample of agreements covering over 500 supportive housing units and found that only about 10% of the units actually stated that they were specifically dedicated to the seriously mentally ill. Many units were dedicated to individuals with “special needs,” including people with serious mental illnesses and also individuals who have needs that are not associated with mental illness. Ministry staff explained that most of the supportive housing units were created prior to the time when seriously mentally ill individuals were identified as the priority group for community mental health services. However, there is no requirement that, when units become vacant, first priority be given to the seriously mentally ill.

Prior to the transfer of the housing units to the Ministry of Health and Long-Term Care, the Ministry of Municipal Affairs and Housing conducted operational reviews to monitor the housing providers’ compliance with the financial and operating requirements of the operating agreements. This included assessing whether housing was being provided to the appropriate individuals. We were informed that the Ministry had begun conducting

reviews in the summer of 2002. Since support services are an integral part of supportive housing, it would be beneficial to review, at the same time, support services being provided.

Recommendation

To help ensure that supportive housing serves individuals who are seriously mentally ill and to assist in assessing the need for additional housing, the Ministry should:

- **determine the extent to which existing housing is actually targeting and serving individuals who are seriously mentally ill; and**
- **ensure that first priority is given to the seriously mentally ill.**

Ministry Response

The Ministry will be looking at the targeting of the client group and plans to include the client group as part of the operational review process in mental health projects. The regional offices will include this as part of their review of the annual budgets.

The development of the Common Data Set—Mental Health (CDS—MH) is nearing completion. CDS—MH will provide baseline and current data that will capture mental health clients' living arrangements and types of residence. These data will allow the determination of whether supportive housing is targeted and provided to the seriously mentally ill, in order that the seriously mentally ill can be given the highest priority.

Homes for Special Care Program

The Homes for Special Care Program, which was established in 1964 under the *Homes for Special Care Act*, provides accommodation in private residences with 24-hour supervision and assistance with activities of daily living. As of March 2002, there were 157 homes that, during the 2001/02 fiscal year, served approximately 1,800 individuals at an estimated cost of \$28.6 million. Provincially run psychiatric hospitals and psychiatric hospitals that have been divested by the province are responsible for placing individuals in homes for special care.

The *Homes for Special Care Act* and regulations require that homes for special care are licensed annually. Inspections are conducted by staff from the psychiatric hospitals that place individuals in the homes, in conjunction with inspections by the local fire department and public health unit. All reports are forwarded to the Ministry. We reviewed a sample of files at the Ministry and noted that annual inspections of homes for special care were often not received by the Ministry on a timely basis.

Although the *Homes for Special Care Act* does not stipulate any standards for the quality of resident care, July 2001 updated interim operating guidelines issued by the Ministry set out the minimum standards of care along with specific indicators to be used in the assessment and monitoring of those standards. We were advised that regional training on these guidelines has been provided. In our *1997 Annual Report*, we noted that while homes for special care were inspected for adherence to the guidelines in place, compliance was not a requirement for licence renewal, and this was still the case at the time of our current audit.

Recommendation

To ensure that Homes for Special Care provide appropriate and consistent resident care across the province, the Ministry should ensure that:

- inspections of the homes are completed and followed up on and deficiencies are corrected on a timely basis; and
- adherence by the homes to minimum standards of care is a condition for licence renewal.

Ministry Response

Annual inspections of the Homes for Special Care are completed in the fall of each year. However, co-ordination with the required public health and fire inspections is not within program control. Licences are not issued without all inspections being completed. A large number of the homes are located in rural areas, so annual inspections are done by volunteer fire departments, and timing is often problematic. Also, some municipal fire departments feel these inspections are not part of their role and are starting to balk at doing them, particularly when asked to do them within the program timetable.

Residential Home Reports are completed by field staff and accompany the fire and public health reports as part of the annual re-licensing process. Following the regionalization of the program and the hiring of regional co-ordinators, these Residential Home Reports are now being monitored closely. When needed, licences are granted with written notification of areas of concern that, if not rectified, may result in the Minister exercising other options, such as non-renewal of a licence. These homes are monitored while non-compliance issues are being resolved. Outstanding issues relating to non-compliant homes are being tracked to their necessary resolution, and actions are being taken to cease business with those unwilling to meet the established goals.

EARLY INTERVENTION PROGRAMS

Early intervention programs offer strategies designed to limit the duration of a psychosis and prevent relapse for people experiencing their first episode of psychotic illness. The strategies make use of antipsychotic medication, psychosocial rehabilitation, and family support and

education. The “Best Practice Checklist”, part of the document entitled *Accountability and Performance Indicators of Mental Health Services and Supports* prepared by the Federal/Provincial/Territorial Advisory Network on Mental Health, recommends the addition of early intervention programs within the continuum of care programs in a reformed mental health system.

In 1999, the Ontario Working Group on Early Intervention in Psychosis was formed to develop an effective treatment and support system for the early stages of psychosis. On January 31, 2001, the working group submitted a comprehensive proposal for the first phase of its provincial strategy for early intervention in psychosis. At the time of our audit, the proposal was being considered in the context of work being done by the Mental Health Implementation Task Forces.

In addition, in the 2001/02 fiscal year, the Ministry provided funding to the Ontario Mental Health Foundation to undertake a two-year descriptive study of individuals who are experiencing the onset of first-episode psychosis. The study is being conducted at four early-intervention treatment programs operating in Ontario. Results of the study are expected in Spring 2003.

We will follow up on the Ministry’s early intervention activities during our next audit of community mental health.

ASSERTIVE COMMUNITY TREATMENT

Assertive community treatment (ACT) was developed approximately 30 years ago by health-care professionals concerned about the continual re-admission of psychiatric patients to psychiatric hospitals. ACT is designed to provide care in the community for individuals with serious and persistent mental health problems, including treatment, rehabilitation, and support services. A multi-disciplinary team provides care 24 hours a day, seven days a week. Contacts with mentally ill individuals served by the team are designed to be flexible and available for as long as needed by the individuals.

ACT teams usually comprise 10 to 12 full-time clinical staff serving individuals with severe symptoms and impairments, some of whom may be hesitant to access community mental health services or may otherwise be hospitalized. Accordingly, staff-client ratios are low.

The first Ontario ACT team was formed in 1990. In 1998, the Ministry began to implement ACT across the province. As of March 2002, there were about 60 ACT teams in Ontario, of which approximately 45 were funded through community mental health. The remainder are funded through hospital budgets. In the 2001/02 fiscal year, expenditures for ACT teams funded through community mental health totalled approximately \$45 million.

Need for Assertive Community Treatment

Various studies indicate that ACT is an effective way of caring for seriously mentally ill people in the community, with benefits that include improved retention in treatment programs and greater housing stability. Research also indicates that when ACT is targeted at high users of hospital inpatient care, it may result in savings. However, since ACT is a high-cost program, it is critical that it be correctly targeted to individuals requiring ACT services and not include those who would do equally well in less intensive, lower-cost programs.

The Ministry has not determined the total number of teams required or the number of teams required in different regions of the province. The required number and distribution of teams is affected by various factors, including the availability of less intensive, lower-cost services. The Ministry indicated that it is awaiting the recommendations of the Mental Health Implementation Task Forces, which may impact on the assertive community treatment program and other services.

Research indicates that, over time, some ACT clients can be well served by less intensive and less costly services with no negative effects. The Ministry's standards for ACT teams include criteria for discharging clients based on improved functioning and a consistent pattern of decreased need for ACT services. However, the Ministry has not determined how less intensive services for clients discharged from ACT should be structured. Other jurisdictions have implemented a multi-tiered system of caring for seriously mentally ill clients that includes less intensive services.

Monitoring Assertive Community Treatment Teams

In 1998, the Ministry adopted standards for its ACT teams. These standards deal with the structure and functions of the teams and admission and discharge criteria. The Ministry included mandatory adherence to the standards in service agreements with ACT teams and initially planned to have most established teams sign such agreements by March 31, 1999. However, in the three regions we visited, we found that most ACT teams had not yet signed agreements. Ministry staff indicated that they planned to have service agreements in place for most ACT teams by early in the 2002/03 fiscal year.

The Ministry monitors the performance of ACT teams through the review of operating plans and through a process similar to accreditation, whereby ACT teams are assessed for compliance with Ontario's ACT standards and adherence to expert consensus on ACT best practices.

However, the Ministry has no computerized information system that routinely collects information from ACT teams. In March 2001, the Ministry conducted a pilot survey on how many individuals ACT teams served and whether the teams were serving the target population. Although the Ministry had some concerns about the quality of the data obtained, the survey results suggested that ACT teams were serving the intended population. The survey also indicated that the average regional caseload varied from 17 to

32 clients per team, with an overall provincial average of 30 clients. Generally, a full caseload consists of 80 to 100 clients per team.

Ministry staff informed us that many teams were still relatively new at the time of the survey, and it was expected that a spring 2002 survey would indicate that most teams were closer to their full caseload. The Ministry indicated that it expects teams to reach full capacity in two to three years and that it is awaiting the reports and recommendations of the Mental Health Implementation Task Forces.

Recommendation

To help ensure the efficient, effective, and appropriate use of Assertive Community Treatment (ACT) teams, the Ministry should:

- **determine the required number and distribution of ACT teams for the province;**
- **monitor ACT teams to ensure that they are serving the seriously and persistently mentally ill target population; and**
- **ensure there are adequate services available to meet the needs of individuals no longer requiring ACT services.**

Ministry Response

As part of their mandated role, Mental Health Implementation Task Forces will be recommending future funding priorities for community services, including ACT teams. Information contained in the community assessment projects will inform the Ministry on the level of need and the services required. With the assessments completed at all current and former provincial psychiatric hospitals, the Ministry will have a very good basis for determining the number and distribution of future ACT teams and other required services.

The Ministry has initiated the second year of a monitoring and outcome survey for all ACT teams and plans to continue this through a future, larger community mental health information system.

Currently, the level of need for those no longer requiring the level of care provided by an ACT team must be assessed by the individual team. Case-by-case planning will be completed in conjunction with the current existing services in that area.

FUNDING

The need for community mental health services in a geographical area is largely dependent on the prevalence of serious mental illness in the local population. Many factors contribute to the incidence of mental illness. For example, research indicates that certain mental

illnesses are more prevalent in certain age groups, and poorer areas appear to have significantly higher rates of serious mental health problems.

Ministry funding for community mental health programs is primarily historically based—that is, the amount of funding disbursed in any year is based on the amount disbursed in the previous year. Since 1992, there have been no increases in base funding provided to community mental health agencies for programs that were operating at that time. In that regard, in June 2001, one district health council, as part of its review of annual operating plans, noted that “as a result of not having had an increase to their base budget in several years, yet having to contend with such pressures as pay equity legislation, rising rental and utility costs, technology infrastructure requirements, increasing transportation costs and the need to offer competitive staff remuneration, community mental health agencies have been forced to reduce services to the seriously mentally ill in order to stay within existing base budgets.”

A recent analysis performed by the Ministry identified significant variations in the per person funding for community mental health services among the different regions of the province. While the average provincial per capita rate in the 2001/02 fiscal year was \$26, the per capita funding in six of the seven regions of the province ranged from approximately \$11 to \$34. The per capita funding in the seventh region was approximately \$60.

At the time of our audit, the Ministry had not developed a funding formula that takes into account the relative need for services and the costs of delivering services in the different regions of the province. Funding based on assessed need helps ensure that individuals with similar needs have access to similar services regardless of where they live in the province. At least two other jurisdictions outside Canada fund mental health services based on an assessment of need.

Similarly, in its 1999 advice to the Minister, the Health Services Restructuring Commission stated that it “continues to support the importance of linking allocation of resources to benchmarks based in the characteristics of the population served (i.e., needs-based funding) in the medium to long term.”

Recommendation

To ensure that community mental health funding provided to regions and agencies is reasonable and equitable, the Ministry should develop a process that provides funding based on an assessment of services needed and of the resources required to meet those needs.

Ministry Response

The Ministry is in the process of converting the existing Community Mental Health (CMH) Budget & Inventory System to a CMH MIS (Management Information Systems) chart of accounts in the Ontario Hospital Reporting System. The MIS chart of accounts will provide the Ministry with more details

for in-year reporting using standard financial and statistical accounts and consistent definitions of mental health services. This will allow the comparison of expenditures across and within the various mental health sectors.

The Ministry is also in the process of setting up the Common Data Set—Mental Health (CDS—MH). It employs the same set of mental health services that are defined in the CMH MIS chart of accounts. The collection of data for this data set will be enhanced substantially by aggregating and reporting client-level data using the client linkage system.

The CDS—MH will assist the Ministry to move towards reasonable and equitable funding for community mental health agencies.