

Chapter 3

Section 3.06

Ministry of Health and Long-Term Care

Community Mental Health

Background

The *Local Health System Integration Act, 2006* provides for an integrated health-care system to improve the health of Ontarians through better access to health services and better co-ordination of health care both locally and across the province. It established 14 Local Health Integration Networks (LHINs), which are responsible for the effective and efficient management of the health-care system at the local level. Effective April 1, 2007, the 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 service providers began reporting directly to their respective LHINs rather than to the Ministry. The LHINs assumed responsibility for prioritizing, planning, and funding certain health-care services, including community-mental-health services. A Ministry/LHIN Accountability Agreement that sets out the accountability relationship between the Ministry and each LHIN outlined the types of mental-health services to be managed by LHINs and those to be managed by the Ministry. Figure 1 breaks down 2006/07 community-mental-health expenditures into the Ministry-managed and LHIN-managed services.

The Ministry provides transfer payments to the LHINs, who fund about 330 community-based service providers for the delivery of mental-health services. The major types of programs funded include housing, case management, multidisciplinary treatment teams (known as Assertive Community Treatment teams), crisis intervention, and counselling and treatment. These programs are primarily designed to treat the estimated 2.5% of the population 16 years and over with a serious mental illness. This population is characterized by what are referred to as the “Three Ds”: a *diagnosis* of mental illness such as schizophrenia, depression, bipolar disorder, or personality disorder; a long *duration* of illness; and a significant *disability* in day-to-day functioning. Figure 2 illustrates the 2006/07 expenditures according to type of service.

Funding to community-mental-health services in Ontario totalled about \$647 million in the 2007/08 fiscal year, up from \$390 million in 2001/02, the time of our last audit.

In 1976, the Ministry began funding community-based mental-health services, and, since that time, mental-health policy in Ontario has evolved from one of institutional care in psychiatric hospitals to one where most of the emphasis is on community-based care. This redirection in policy, commonly referred to as mental-health reform, is intended to create an efficient and integrated system that would

Figure 1: Management Responsibility and Expenditures for Community-mental-health Services, 2006/07

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

Service	Managed by	Expenditures (\$ million)	% of Total Expenditures
supportive housing ¹	Ministry	55.8	9
Homes for Special Care Program ²	Ministry	28.9	5
services provided by certain provincial organizations ³	Ministry	14.5	2
remaining services ⁴	LHINs	496.3	83
Total		594.5	100

1. bricks and mortar components only—not the supportive services that come with the housing units
2. a program established in 1964 under the *Homes for Special Care Act* to provide accommodation in private residences with 24-hour supervision and assistance with activities of daily living
3. These organizations are transfer-payment agencies that, owing to their provincial mandate, cannot be allocated to specific LHINs. For example, the Ontario Federation of Community Mental Health and Addictions Programs is the provincial organization representing all community-mental-health and addiction agencies across the province, so it would not be appropriate for a particular LHIN to manage it. The Ministry manages about 10 such agencies in the mental-health field.
4. Examples include Assertive Community Treatment, case management, crisis intervention, short-term residential crisis beds, early intervention in psychosis, and diversion/court support.

meet the needs of people with serious mental illness in the most appropriate, effective, and least restrictive setting. As part of this reform, since 1998, the Ministry has divested itself of or transferred nine of 10 provincial psychiatric hospitals to public hospitals and community-based service providers.

Audit Objective and Scope

The objective of our audit was to assess whether the Ministry, in partnership with the Local Health Integration Networks (LHINs) and the community-based service providers, has mechanisms in place to:

- meet the needs of people requiring mental-health treatment services;
- monitor payments and services to ensure that relevant legislation, agreements, and policies are followed; and
- measure and report on the effectiveness of its community-mental-health programs.

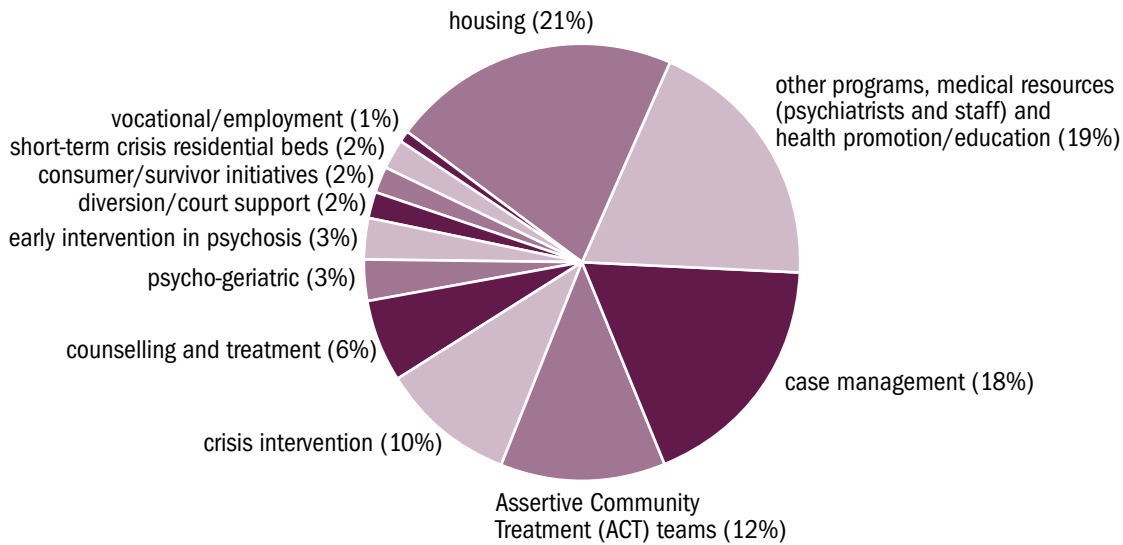
In conducting our audit, we reviewed and analyzed relevant information available at the Ministry

and visited three LHINs and two community-mental-health service providers in each of the three LHINs. We also met with representatives from stakeholder organizations, including the Centre for Addiction and Mental Health, the Canadian Mental Health Association, and the Ontario Federation of Community Mental Health and Addiction Programs. We reviewed relevant literature and researched practices in community-mental-health delivery in other jurisdictions. We also reviewed and, where warranted, relied on work completed by the Ministry's internal audit services.

Our audit followed the professional standards of the Canadian Institute for Chartered Accountants for assessing value for money and compliance. We set an objective for what we wanted to achieve in the audit and developed audit criteria that covered the key systems, policies, and procedures that should be in place and operating effectively. We discussed these criteria with senior management at the Ministry. Finally, we designed and conducted tests and procedures to address our audit objective and criteria.

Figure 2: Components of Community-mental-health Expenditures, 2006/07 (%)

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



Summary

In both our 1997 and 2002 audits of community-mental-health services, we expressed concern that Ontario had not yet established clear expectations for the level of community-based services that the seriously mentally ill could expect to receive. As well, it did not have sufficient information on whether the level of care being provided by community-based service providers was sufficient to enable people with mental illness to live fulfilling lives in their local communities. Our current audit indicates that, while the Ministry has made some progress, many of these concerns have not yet been adequately addressed. With respect to its goal of replacing institution-based treatment with community-based treatment and suitable housing, the Ministry has made good progress in reducing the number of mentally ill people in institutions. However, the success of this strategy is dependent on adequate community-based support systems. As the following observations indicate, the Ministry, working with the LHINs and its community-based partners, still has significant work to do in this area:

- The Ministry has almost reached its interim deinstitutionalization target of reducing the number of psychiatric beds to 35 per 100,000 people. However, the Ministry was still far from achieving its community target of spending 60% of mental-health funding to meet the needs of people with serious mental illness in the community. In the 2006/07 fiscal year, the Ministry spent about \$39 on community-based services for every \$61 it spent on institutional services.
- According to a report released by the Centre for Addiction and Mental Health in 2004, over half of the people with serious mental illness living in the community were not receiving an appropriate level of care. The study also identified a high rate of unmet need, especially for intensive community services. As well, of those persons with mental illness in hospitals, over half could be discharged into the community if the necessary community services were available. While the Ministry has made major investments in community care subsequent to this study, the LHINs and service providers we visited indicated that this was still an issue in the communities.

- There were lengthy wait times for services. Excluding supportive housing programs, community-mental-health services had wait times of about 180 days on average, ranging from a minimum of eight weeks to a year or more.
 - While we noted some local co-ordination initiatives that should be considered best practices, formal co-ordination and collaboration among stakeholders—including community-mental-health service providers, the relevant ministries, and the LHINs—was generally lacking.
 - The Ministry transferred the delivery of community-mental-health services to the LHINs on April 1, 2007. However, the LHINs we visited indicated that they were still learning how to effectively oversee and co-ordinate community-mental-health programs.
 - Although new funding from the federal government and from the province's Service Enhancement initiative have increased capacity in the community sector, over half of community-mental-health service providers have received annual increases of only 1.5% over the last few years. Service providers indicated that, as a result, they were significantly challenged in their ability to maintain community service levels and qualified staff.
 - The funding of community-based programs continues to be based on past funding levels rather than on actual needs. The historically based funding has resulted in significant differences in regional average per capita funding, ranging from a high of \$115 to a low of \$19 depending on where in Ontario one lives, which may not be reflective of current population needs.
 - Overall, there is a critical shortage of supportive housing units in Ontario, with wait times ranging from one to six years. We also found that such units were unevenly distributed throughout the province, ranging from 20 units per 100,000 people in one LHIN to 273 units per 100,000 people in another. While some regions experienced a serious shortage, others had significant vacancy rates, which were as high as 26% in the Greater Toronto Area.
 - The Ministry has not adequately monitored payments to service providers. We noted cases in which the Ministry provided capital funding to housing providers to repair supportive housing units without ensuring that the work was being done in a timely and cost-effective manner.
 - The Ministry's 1999 *Making It Happen* policy document confirmed the necessity of developing explicit operational goals and performance indicators. While its 2007 Mental Health System Scorecard is a step in the right direction, significant work is still required before the Ministry and the LHINs have sufficient information to assess the adequacy of community-based care that people with serious mental illness are actually receiving.
 - Since our last audit in 2002, the Ministry has successfully implemented two new systems to collect data for the community-mental-health sector, with 80% to 90% of service providers submitting data and complying with the reporting requirements. While this was a good initiative, more attention is needed to ensure the data collected is complete, accurate, and useful so that it can be used to measure and report on the effectiveness of community-mental-health services.
 - Service providers' operating plans provide valuable quantitative and qualitative information that enables the Ministry and the LHINs to gain an understanding of and monitor service providers' operations. However, for the 2007/08 fiscal year, service providers were not required to submit operating plans.
- Many of the issues above are also the main concerns of the LHINs we visited. Examples identified by the LHINs are the significant wage disparities between the community and institutional sectors,

the risk that service volumes will be reduced owing to inadequate increases in base funding, the failure to move people with mental illness from hospitals to a more appropriate level of care, service gaps in supportive housing, and the absence of new funding to support co-ordination and access initiatives.

OVERALL MINISTRY RESPONSE

In keeping with the Ministry's Mental Health Reform strategy, the Ministry has focused on providing community services for the seriously mentally ill. Since 2003, the Ministry has improved capacity and made program changes through increased funding to community-mental-health agencies by more than \$200 million, a 50% increase.

The majority of the funding has been targeted to specific programs that best met the needs of the seriously mentally ill. This includes Health Care Accord funding of \$117 million allocated to support Assertive Community Treatment Teams, intensive case management, crisis intervention, and early psychosis intervention. The Ministry also provided an additional \$50 million to keep people with serious mental illness out of the criminal justice system, funding crisis response/outreach, short-term residential crisis-support beds, supportive housing, court support services, and intensive case management services. In addition, funding has increased for eating disorder services, Aboriginal mental-health services in Aboriginal Health Access Centres, and consumer/survivor initiatives. Finally, the Ministry has provided stabilization increases for all community-mental-health programs.

The Ministry has been engaged in a four-year evaluation of the new funding's impact and expects a report on this in summer 2009.

In 2003, the Ministry began funding of ConnexOntario to provide clients, families, and providers with 24-hour access to community services across the province as well as a referral

service. This will be reviewed for the feasibility of providing wait-time information.

In terms of improved data, since 2002, the Ministry has been phasing in two information systems to increase the government's ability to monitor the community-mental-health system. This was a large undertaking, as minimal data reporting previously existed. The Ministry appreciates that information will improve over time.

In 2007, the Ministry began a pilot project for a Common Assessment Tool for community mental health to assist agencies in assessing client service needs so that clients get the services they need when they need them. Results are expected this year and the Ministry will then consider full implementation. As well, the Ministry published the Mental Health Strategy Map and Mental Health Scorecard, which set out performance indicators. The Ministry is committed to developing this further in the future.

These improvements have all been accomplished at a time of transition. Regional Offices were closed in March 2007, the 14 Local Health Integration Networks (LHINs) were established, and ministry responsibilities devolved to the LHINs on April 1, 2007.

The Ministry continues to be responsible for legislation, policy, and program standards, while the LHINs plan, fund, and manage local health-service providers through accountability agreements. The Ministry and LHINs are working together closely to achieve success for the health system.

OVERALL LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

The LHIN responses in this report are joint responses from the three LHINs we visited as part of our audit.

The Central, Champlain, and South West LHINs feel this is an excellent report that provides a status update on client access to service, funding for provider remuneration, and the supply

of adequate housing. It also addresses needs for proper evaluation of program standards, performance measures, monitoring, and accountability. Based on extensive community consultation leading up to the development of our Integrated Health Service Plans (IHSPs), the majority of LHINs identified mental health as a priority, and we therefore welcome your recommendations.

We appreciate the report's identification of the issues faced by the LHINs. The report documents a number of long-standing challenges in this sector and points out the LHINs will need to work with the Ministry to meet the needs of Ontarians with mental illness. The report will be helpful to the LHINs to fulfill our mandates.

The report goes on to identify a number of ways the Ministry could better equip the LHINs to fulfill our mandate of working with local health-service providers to generate reliable data that can be used to monitor and improve services, and to enhance collaboration and coordination within the sector.

Detailed Audit Observations

MENTAL-HEALTH STRATEGY

Impact of Mental Illness

Addressing the needs of people with mental illness is a pressing issue for Ontario's health-care system and society as a whole. Various recent studies show that:

- Mental illness affects everyone. One in five Ontarians will experience a mental illness in some form and to some degree in their lifetime. Four out of five will be affected by a mental illness in family members, friends, or colleagues.
- Among those Ontarians with mental illness, about 2.5% will experience what is catego-

rized as serious mental illness, involving profound suffering and persistent disablement.

- People with serious mental illness are likely to be living in poverty. About one-third are homeless and over 70% are unemployed.
- According to the Canadian Mental Health Association, there is a strong correlation between suicide and mental illness. It is estimated that 90% of suicide victims—about 900 suicide cases in Ontario each year—have a diagnosable mental illness.
- According to the London Police Department, the police and criminal justice sector are handling an increasing number of people with severe mental illness, creating pressure on the justice system. For example, police in London, Ontario, have doubled the time they spend dealing with people with serious mental illness in recent years.
- In addition to affecting individuals and their families, mental illness also creates a heavy burden on the economy. According to a study released by the Centre for Addiction and Mental Health in 2006, the estimated total economic cost attributable to mental illness was about \$22 billion per year in Ontario.

Ontario Mental-health Strategy

Mental-health policy in Ontario has been moving from one of confining people with serious mental illness in institutions to one of serving them in the community with appropriate and accessible services. This strategy is based on research indicating that community-based care is more effective and cost-efficient. For example:

- To keep someone with serious mental illness in a hospital for a year costs over \$171,000. For jail, the yearly cost can range from \$100,000 to \$250,000. In contrast, it only costs about \$34,000 per year to support the same person with mental-health services in the community.

- Community-based mental-health services relieve pressure on other expensive and overburdened services. A Canadian Mental Health Association study showed that, with proper community supports, people use hospital and police services significantly less often. The study cited 86% fewer hospitalizations, 60% fewer emergency room visits, and 34% fewer police interventions.
- Most crimes committed by the mentally ill can be prevented if adequate and appropriate supports are available in the community.

In 1999, the Ministry released *Making It Happen*, a key policy document outlining what was then the Ministry's three-year strategy for restructuring the mental-health system to "support much needed changes in the way services are delivered." The document contained an implementation plan providing the context for the overall reform, and a framework with detailed directions and guidelines for the organization and delivery of core services within the reformed mental-health system.

Mental-health reform requires shifting some existing resources from hospitals to community services. For this reason, the Ministry, in *Making It Happen*, established specific targets and timelines for the number of psychiatric beds it would fund, and the relationship of this funding to funding for community-based services. Essentially, the Ministry determined that the mental-health system should have a 60:40 ratio of spending on community-based services to in-patient services, and that there should be 30 psychiatric beds for every 100,000 Ontarians. Based on recommendations from the Health Services Restructuring Commission in 1999, the Ministry subsequently set an interim target of 35 beds per 100,000 people. It committed to meeting these targets by 2003.

Ministry staff indicated that these targets are still currently relevant and applicable. We found that the Ministry has almost reached its interim target of reducing the number of beds to 35 per 100,000 people—reducing the number of beds per 100,000 people from 40 in 2002/03 to 36 in

2006/07 (see Figure 3). While the Ministry has increased funding for community-mental-health programs, it has still not achieved its target of spending 60% of mental-health funding on community-based services. In the 2006/07 fiscal year, the Ministry spent about \$39 on community-based services for every \$61 it spent on institutional services. While the Ministry has almost met its target of reducing the number of beds, it has not met the community-based spending-target ratio. The Ministry indicated that the funding-target ratio has not been reached mainly due to the complexity of escalating hospital costs.

The fact that the Ministry has reduced the number of beds significantly yet not met the community-based funding-target ratio suggests that adequate community-based supports may not be available for people being discharged from psychiatric hospitals as a result of bed closures. The success of the restructuring depended upon sufficient community capacity being in place prior to the closure of beds. If people with serious mental illness are released into the community without such services, there is a much higher risk that they will need to be hospitalized or commit acts requiring police intervention.

Figure 3: Status of Community-mental-health Targets for Funding and Number of Beds, 2002/03–2006/07

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

	# of Hospital Psychiatric Beds per 100,000 People	Ratio of Community to Institutional Funding
Target	35*	60:40
Actual		
2002/03	40	28:72
2003/04	39	27:73
2004/05	38	28:72
2005/06	37	29:71
2006/07	36	39:61

* The Health Services Restructuring Commission (HSRC) supported an original rate of 30 beds/100,000 population as the ultimate target. However, to ensure that the pace of change is appropriate to achieve an orderly restructuring of mental-health services, the HSRC proposed interim guidelines of 37 beds/100,000 by 2000 and 35 beds/100,000 by 2003.

According to the *Ontario Hospital Report on Mental Health 2004*, hospital readmission and repeat in-patient rates indicate that there was a gap between institutionalized and community-based mental-health services. Too many individuals were returning to hospitals for care because there were poor integration of services, poor community follow-up, inefficient or inappropriate use of resources, poor planning or preparation for discharge, and insufficient help to people attempting to maintain themselves in the community rather than in an institutional setting. The report noted the following:

- Twenty-two percent of people with mental-health issues discharged in Ontario are either readmitted to hospital or seen in an emergency department within 30 days of discharge.
- Twenty-six percent of Ontarians hospitalized for mental illness had multiple admissions during one year.

The LHINs we visited indicated that their hospitals still faced challenges regarding the provision of appropriate continuity of care between the institutional- and community-based settings (see Level of Care section of this report).

RECOMMENDATION 1

To better ensure that Ontario's strategy of serving people with serious mental illness in the community rather than in an institutional setting is implemented effectively, the Local Health Integration Networks (LHINs), in consultation with the Ministry of Health and Long-Term Care, should provide the community capacity and resources needed to serve people with serious mental illness being discharged from institutional settings.

MINISTRY RESPONSE

The LHINs have been mandated to plan for health services of their communities, including those with mental-health problems.

Since 2004/05, the Ministry has increased community-mental-health budgets by over \$200 million and will continue to invest in this area so that LHINs can develop more community capacity.

This new funding was directed at community-mental-health programs to ensure capacity as people with serious mental illness were being discharged from institutions. In addition, the government has committed an additional \$20 million starting in the 2008/09 fiscal year to support community-mental-health initiatives that have an impact on emergency department wait times.

LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

In full endorsement of the Ontario Mental Health Strategy, the LHINs recognize the need to serve people with mental illness in the community, thereby reducing reliance on less cost-effective institutional beds. While additional resources—specifically, mental-health programming, social supports, and housing—are necessary, the LHINs are committed to improving co-ordination and fostering collaboration among local health-service providers to increase the effectiveness of resources currently available.

ACCESS TO SERVICES

Making It Happen stated that each person with serious mental illness should have access to treatment, rehabilitation, and support services. With deinstitutionalization, timely access to community-based mental-health services is critical for ensuring the best possible outcomes for people with mental illness. However, we noted that timely access to appropriate community-mental-health care is not always available across the province.

Level of Care

The Centre for Addiction and Mental Health conducted a series of Comprehensive Assessment Projects from 1998 to 2002 across the province. These projects assigned clients to one of five levels based on their ability to function independently in the community, overall problem severity, risk issues, and personal strengths (see Figure 4).

The projects demonstrated that a sizable proportion of clients with serious mental illness could be treated in the community given appropriate levels of service and support. They also provided information about the service use and needs of individuals with serious mental illness, and quantified the service capacity. The projects were completed by the end of 2002 and a summary report issued in 2004. The report compared client needs with the care being provided across the province and concluded that people with mental illness were not receiving the proper level of care. For example, only one-third of clients received the appropriate level of care and over half of the persons with mental illness in hospitals could live independently in the community if appropriate supports were available.

The Canadian Institute for Health Information released a report, *Hospital Mental Health Services in Canada 2003/04*, which also pointed to the mental-health system's inability to transfer people with mental illness to a more appropriate level of care. The report noted that 10.9% of all hospital days attributable to mental illness—about 75,000 per year in Ontario—were deemed to be no longer necessary, meaning that people with mental illness could have been discharged to a more appropriate level of care in the community.

Despite new funding initiatives introduced to the mental-health system, this is still an issue according to the LHINs and service providers we visited (see the New Funding Initiatives section of this report). One LHIN noted that hospitals across its region continued to experience pressures to move people with serious mental illness from hospitals to a more appropriate level of care. One of the

Figure 4: Levels of Care for Persons with Serious Mental Illness

Source of data: Comprehensive Assessment Projects by the Centre for Addiction and Mental Health

- 1 "self-management." The client sees a mental-health professional or family doctor once a month or less. Clients navigate the system without case management
- 2 case management. Support provided about once per week on average
- 3 intensive case management or Assertive Community Treatment (ACT). Clients need more than weekly follow-up, typically several times per week, with a strong clinical and rehabilitation component
- 4 residential treatment, with 24-hour intensive supervision and rehabilitation, and provision for up to daily access to clinical treatment, as needed
- 5 long-term hospitalization

hospitals in this LHIN indicated that the number of hospital days attributable to mental illness that were deemed to be unnecessary is increasing. Another LHIN also noted that an inadequate supply of community services forces people with serious mental illness to use higher-cost services such as emergency rooms and hospitals.

Wait Lists and Times

In our *2002 Annual Report*, we noted that inadequate information about wait lists and times limited the Ministry's ability to assess whether sufficient and appropriate services were available to meet the needs of the seriously mentally ill. During our current audit, we noted that the Ministry had taken the initiative to address this issue by implementing two new systems to collect data for the community-mental-health sector: the Management Information System (MIS) and the Common Data Set-Mental Health (CDS-MH) system. (See the section Information Systems for further detail.)

However, as with any information systems, their usefulness depends upon the accuracy and consistency of information collected. We had concerns about the information on wait lists and times collected in these new systems. Ministry staff told us

that this information cannot be used for practical analysis at the provincial level, and comparison among service providers is impossible because reporting needs improvement. Service providers either did not report on wait times or reported inconsistently because they were confused about the definitions of wait times and when to start and end their wait-time calculations. Because ministry information could not be relied upon, we did our own research that indicated that actual wait times were lengthy. Specifically:

- Ministry staff indicated that the average wait time for community-mental-health services was somewhere over 180 days.
- A report released by the Ontario Federation of Community Mental Health and Addiction Programs in 2003 indicated that almost half of the people who need services must wait eight weeks or more and the wait time for 18% of community-mental-health programs can be a year or longer.
- A report by the Fraser Institute in 2007 indicated that people seeking mental-health treatment are likely to be disappointed with their access to it. According to the report, in Ontario, wait times from referral by a general practitioner to treatment exceed four months, and wait times from a meeting with a specialist to treatment are more than 148% longer than psychiatrists feel is appropriate. The report concludes that a great many people with mental illness are experiencing a deterioration of their condition before they get the care they need.
- The service providers we visited in early 2008 generally had long wait lists and wait times. For example, one service provider indicated that its wait list had 85 clients, who had been waiting for community-based services for four to eight months. Two service providers stated that wait times for access to psychiatrists could range from two to six months. Two other service providers told us that it took about eight months to a year for clients to get

services from selected Assertive Community Treatment teams.

Co-ordination of Access to Services

Released in 1999, *Making It Happen* stated that “access to mental health services in Ontario can be confusing and time-consuming for clients and their families/key supports.” Nine years later, this continues to be an issue. At the time of our current audit, we noted that there was a lack of formal co-ordination and collaborative process among the various stakeholders, including the community-mental-health service providers, the relevant ministries, and the LHINs.

Between Community-mental-health Service Providers

Since April 2007, the LHINs have been responsible for co-ordination among service providers, but in many areas of the province there is still minimal co-ordination among service providers that provide similar or identical services. One of the reasons the LHINs were created was that the Ministry was concerned about the lack of co-ordination and integration of services in the community-mental-health sector—in essence, the sector was a confusing system of many service providers and multiple access points. During our visits to the LHINs and service providers, we noted that co-ordination of access to services were generally lacking. Specifically:

- A survey by one LHIN found that lack of co-ordination and lack of access to services were the most mentioned gaps or challenges identified by the service providers.
- There has been no funding specifically for co-ordination. The LHINs as part of their mandate encourage service providers to work together, but we were advised that, without specific funding, this is less likely to occur. Smaller service providers are at a particular disadvantage because they can spare fewer resources for co-ordination.

- There was no guidance from the Ministry or the LHINs to service providers on how co-ordination of access was to be done.
- Service providers developed programs and operated in isolation from one another, in what is often referred to as a “silo mentality.” This has fragmented what should be a continuum of care. Different service providers have developed different processes for such key activities as assessing clients, determining eligibility, and referring clients to other services. This lack of consistency has led to duplicated efforts, disjointed services, and clumsy transitions between services.
- The Ministry’s initiative in funding centralized serves provided by ConnexOntario has not been expanded to include important information, such as availability of a service at a particular point in time and what the wait times might be.

Notwithstanding these observations, we note that the Ministry has introduced a common assessment tool to ensure the consistency of assessing clients in the community-mental-health sector. As well, we did note some local initiatives that should be considered best practices. These include collaborative partnerships, centralized and triage wait lists, and centralized intake processes. Such initiatives help to reduce wait times, eliminate confusion for clients, and facilitate a more accessible and co-ordinated system. The Ministry and the LHINs should encourage and support the adoption of these best practices to enhance co-ordination.

Between Ministries

Co-ordination between ministries needs significant improvement, especially in serving people with what is referred to as “dual diagnosis”—a mental illness combined with a developmental disability of significantly below-average intellectual and adaptive functioning. People with dual diagnosis obtain services through two distinct sectors: the developmental sector, funded by the Ministry of

Community and Social Services, and the mental-health sector, funded by the Ministry of Health and Long-Term Care. One service provider we visited that deals with people with dual diagnosis mentioned that the ministries did not agree on the definition of dual diagnosis. A research study issued by the Ontario Mental Health Foundation in December 2005 also noted inadequate collaboration between ministries:

- The guidelines released jointly by the two ministries in 1997 were unclear in terms of who was eligible for services and the responsibilities of each ministry to provide such services. This lack of clarity resulted in people being denied services by both ministries. As the report put it, clients “ping pong between two sectors.”
- The two ministries developed a work plan in 1998 to describe expected outcomes, target dates, and their responsibilities in implementing the 1997 guidelines. However, the groups that developed the plan disbanded and there has been no follow-up activity. Because of “silos” within the ministries, not enough inter-ministerial planning is presently occurring and communication between regions is limited. In 2005, the two ministries created a new process to update the guidelines, but completion of this work was deferred owing to the introduction of LHINs and the implications for new relationships.

Between the LHINs and the Ministry

Since April 1, 2007, the LHINs have focused on administering and overseeing the delivery of community-mental-health programs while the Ministry has assumed a stewardship role in providing overall direction and leadership for the system. The Ministry created the LHIN Liaison Branch to serve as the primary point of contact for the LHINs, which are, in turn, responsible for relationships with local health-service providers.

In evaluating ministry and LHIN readiness for and execution of the April 1, 2007, transfer of authority to the LHINs, the Ministry's internal audit services identified challenges in several areas, including further clarification of policies, roles, and responsibilities; and the continued need for knowledge transfer from the Ministry and for more timely and useful data if they were to be fully capable of assuming their responsibilities with respect to community mental health.

Our visits to three LHINs in early 2008 confirmed that these challenges still largely remained.

RECOMMENDATION 2

To help ensure that people with serious mental illness have consistent, equitable, and timely access to community-based services that are appropriate to their level of need, the Ministry of Health and Long-Term Care should:

- improve provincial co-ordination with the Local Health Integration Networks (LHINs) and other ministries, which are involved in serving people with mental illness; and
- provide support to the LHINs—particularly in terms of knowledge transfer and data availability—that would enable them to effectively co-ordinate and oversee service providers as intended.

The Local Health Integration Networks should:

- work with service providers to improve the reliability of wait-list and wait-time information;
- collect and analyze wait lists and wait times and use such information in determining the need for and prioritizing specific types and levels of service; and
- provide the necessary assistance to enhance co-ordination and collaboration among health-service providers.

MINISTRY RESPONSE

In 2006, the Ministry funded ConnexOntario for mental-health agencies, where the public can

access information 24 hours a day, seven days a week, about the range of community-mental-health services offered in Ontario. The Ministry also supports the development of an efficient and accountable service system by providing planning information to system managers.

The Ministry agrees that the LHINs will need to work with their health-service providers to ensure that data about their services are regularly uploaded to ConnexOntario. This will ensure that the public has the most up-to-date information and that the LHINs can rely on information from ConnexOntario for service-planning purposes and wait-list management.

The Ministry will work with ConnexOntario to establish provincial wait-time availability as well as standard reporting on wait times.

The Ministry will work with the LHINs and health-care providers to introduce initiatives such as the common-assessment tool. This tool is expected to make a significant contribution to co-ordination and collaboration by enabling providers to share information about their clients during the program admission and discharge process.

The LHINs were created to plan and integrate services. Key to this mandate are improvements to the co-ordination of services to improve access to services and continuity of care for clients requiring mental-health and other services.

To support the LHINs in the assumption of their new roles, the Ministry held numerous and various types of knowledge-transfer and training sessions to familiarize the LHINs with their health-service providers, financial-management processes, health-information management, and other subjects. The Ministry will continue to work with the LHINs to identify knowledge gaps and training needs and provide assistance to them as required.

The Ministry will also continue to work with the LHINs and other ministries where joint approaches are required to impact services to people with mental illness.

LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

Timely access to mental-health services remains the principal barrier to effective care. This point has been underscored in LHIN community-engagement sessions. In an era of tight resources, the Ministry needs to provide the tools for LHINs to work in conjunction with local providers to improve data quality, implement shared and more central intake, and actually manage waiting lists. Equally, both the Ministry and the Ministry of Community and Social Services need to investigate pooling resources for citizens with the most complex needs. Typically, these clients are not well served, and as a result consume disproportionate administrative resources that could be better spent managing waiting lists and allocating resources for less dependent clients before they fall into a crisis.

FUNDING

From the 2003/04 to the 2007/08 fiscal years, community-mental-health expenditures increased by 58%—from \$409 million to \$647 million (see Figure 5). This was mainly attributable to several new funding initiatives, especially \$117 million over four years from the federal government and \$50 million over two years from the Ministry (see New Funding Initiatives).

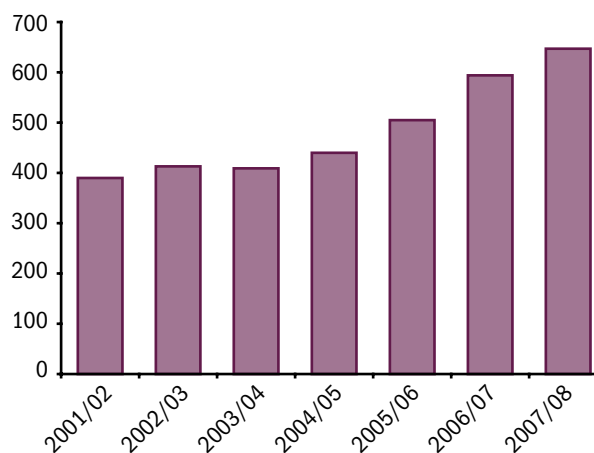
New Funding Initiatives

In recent years, two significant new funding sources added resources to the community-mental-health system to enhance existing services:

- In 2003, the federal government agreed to provide new funding under the First Ministers' Health Care Accord (known as "Accord funding"). Starting in the 2004/05 fiscal year, the federal government allocated \$117 million over four years for the provision of expanded

Figure 5: Community-mental-health Expenditures, 2001/02–2007/08 (\$ million)

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



services in crisis intervention, intensive case management, early intervention in psychosis, and Assertive Community Treatment (ACT) teams. (ACT teams are multidisciplinary teams usually comprised of clinical staff, including a psychiatrist and nurses, plus a social worker, occupational therapist, and other specialists. Each team provides a full range of services to a roster of about 80 to 100 clients.)

- Through its Service Enhancement funding, the Ministry invested \$50 million over two years, starting in the 2004/05 fiscal year, to keep people with serious mental illness out of the criminal justice and correctional system. Programs that received additional funding included short-term residential crisis beds, supportive housing, and diversion/court support (which assists persons with mental illness who are in conflict with the law, and their families, to navigate the legal process and link them to a variety of community-based mental-health services).

While the new strategic investments have increased capacity in the community sector, we found that the new funding was only allocated to certain service providers: the majority of providers received no additional money beyond a 1.5%

annual increase in the last few years. The Ministry indicated that many providers did not receive additional funding because the government targeted the funding to specific programs that met specific program criteria and local needs. When we requested documents setting out these criteria for the allocations of the new funds to the service providers, the Ministry informed us that the decisions were made by the regional offices, which no longer exist, and the documents were not available.

Existing Community-mental-health Programs

Most community-mental-health service providers have indicated to the Ministry that, despite the new funding initiatives, existing programs have remained significantly underfunded. Our review of funding showed that, prior to the 2004/05 fiscal year, community-mental-health programs received no increase in their base funding for more than a decade. In 2004/05, the Ministry provided a 2% increase, followed by a 1.5% increase in each of the 2005/06, 2006/07, and 2007/08 fiscal years. The LHINs we visited stated in their quarterly and annual reports that, following so many years of flat-line budgets, the recent 1.5% increases have been inadequate for service providers to maintain current service levels. Furthermore:

- Service providers anticipated that increases of 3% to 5% are required to match union settlements, merit increases, and inflation. With no further increases expected, service providers have reduced service volumes and staff levels in order to balance their budgets. The service providers we visited indicated that they have also had to freeze wages and cut back on spending for infrastructure such as facilities and information technology.
- A survey conducted in late 2002 by the Ontario Federation of Community Mental Health and Addiction Programs found that 80% of service providers had to close programs temporarily to cope with fiscal pressures, and 25% closed programs permanently.

Almost three-quarters of service providers had lost staff to higher-paying jobs outside the mental-health sector and could not afford to replace them because they were unable to offer competitive salaries.

- Staff turnover within the community-mental-health sector is high—as much as 40% a year in some regions. As well, community-based staff, as in other community-based systems, often receive lower wages than their counterparts in hospitals, making recruitment and retention of qualified staff difficult and eroding the capacity of the community-mental-health system at the very time that more patients were being transferred from institutions back to the community.

Funding Based on Identified Needs

According to the federal document *Review of Best Practices in Mental Health Reform*, the allocation of resources is more effective and equitable when it is based on actual needs rather than on what has been funded in the past. Needs-based funding directs resources to where the need is greatest, regardless of historical relationships with service providers and past patterns of use. In our *2002 Annual Report*, we raised this issue, yet the Ministry has still not implemented a needs-based funding model as a result of the complexity of the community mental-health system.

In 2002, we noted that the historically based funding for community-mental-health programs was contributing to significant variations in per person funding in different regions of the province. As long as increases remain a percentage of the previous year's funding, the LHINs with high historical funding will receive even more in the future regardless of their needs. During our current audit, we found that the significant variations in funding remain. Specifically:

- The average per capita funding for community-mental-health services for the entire province in the 2007/08 fiscal year was about \$42, but it varied from a high of \$115 in one LHIN

(where population was declining) to a low of \$19 in another LHIN (where population was increasing).

- If funding continues to be based on historical patterns rather than population characteristics, needs, and health risks, funding disparity will become even more exaggerated. As Figure 6 shows, the gap between the lowest and the highest per capita funding levels will increase from \$94 in 2006/07 to \$101 in 2009/10. Inequitable regional funding essentially means that people with similar needs may not receive the required services, depending on where in Ontario they live.

The Ministry has acknowledged the problem of historically based funding. To attempt to rectify this, it allocated the new federal Accord funding and its own Service Enhancement funding according to population. However, it did not take into consideration other relevant factors, such as the distance between services, which would improve the formula for allocation. The Ministry has indicated that it plans to implement a needs-based model, the Health Based Allocation Model, in the community-mental-health sector, once it is able to collect the data and cost estimates necessary to properly assess the specific needs of people across the province.

Figure 6: Range in per Capita Funding for Community-mental-health Programs, 2006/07–2009/10 (\$)

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

	Actual		Forecast	
	2006/07	2007/08	2008/09	2009/10
provincial average	40	42	44	44
LHIN with highest level	112	115	120	122
LHIN with lowest level	18	19	20	21
gap between highest and lowest	94	96	100	101

RECOMMENDATION 3

To ensure that people with similar needs are able to receive a similar level of community supports and services, the Ministry of Health and Long-Term Care and the Local Health Integration Networks should collect complete data and adequate 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.

MINISTRY RESPONSE

The LHINs have been mandated to plan for the health needs of their communities, including those with mental-health issues. The majority of LHINs have identified the need to address mental health as a priority and are mandated to realign services within their regions to meet these needs.

To support the LHINs' efforts, the Ministry will continue its work on the new Health Based Allocation Methodology (HBAM) initiative for the community mental-health sector.

LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

The LHINs recognize significant disparities in remuneration for similar work between the institutional and community sectors. As labour shortages increase, the situation will worsen, and unless corrective measures are taken, pay differentials will continue to seriously undermine the strategy to move clients from institutions into the community. Furthermore, as the report correctly points out, resources for programming vary enormously from LHIN to LHIN and from community to community within individual LHINs. The historically uneven distribution of resources results in significant inequities in access to service, and the Ministry needs to help the LHINs to redress the imbalance.

HOUSING

Housing is a key determinant of health, and, as such, is a critical component in an effective community-mental-health system. When people with mental illness have choice and control over their housing, they are more likely to report increased well-being, psychological stability, and independent functioning. Supportive housing is a form of housing that offers individualized, flexible, and rehabilitation-oriented supports to help people with mental illness improve their community-living skills and maximize their independence, privacy, dignity, and decision-making abilities. Various types and levels of support services are provided within the residences, such as case management, social rehabilitation, assertive community treatment, and crisis intervention. Without accessible housing and support, successful community living and recovery are difficult. Homelessness is also a frequent experience of people with serious mental illness in Ontario. On average, 30% to 35% of homeless people have mental-health problems.

The Ministry is the sole provincial funder for both the support services and accommodation components of supportive housing. At the time of our audit, about 7,900 mental-health supportive housing units, managed by 86 housing providers, were available in Ontario. About 3,300 of these units were “dedicated” units and 4,600 were “rent supplement” units:

- Dedicated units are those that have been purchased by housing providers using government funding. They are generally in the form of houses and apartment-style buildings. Housing providers, which are not-for-profit, own and operate these units with the assistance of subsidies from the Ministry to cover operating costs.
- Rent supplement units are those that are located in private apartment buildings. Housing providers work with private landlords to secure these units for their clients. The Ministry pays a rent subsidy to housing pro-

viders to assist with clients’ monthly rental payments.

Housing Needs and Capacity

Making It Happen, released in 1999, stated that “in order to be consistent with current provincial initiatives, the Ministry will need to review the housing needs of [the homeless/socially-isolated] population ... who ... are also mentally ill.” In our *2002 Annual Report*, we noted that the Ministry needed to address the number and types of housing units required in different areas of the province. In our current audit, while we found that recent housing initiatives have attempted to address inequities across the province, further improvements are required.

Availability

There is a critical shortage of supportive housing in Ontario. The federal government’s 2006 report *Out of the Shadows at Last* called for the development of 57,000 more affordable housing units in Canada over the next 10 years to address this shortage. On the basis of Ontario’s population, we estimated that about 23,000 of these units would be needed in Ontario.

The long wait times individuals experience before getting into supportive housing is evidence that the need for supportive housing is much greater than its supply. A study by the Ontario Non-Profit Housing Corporation in 2006 revealed that the average wait time for supportive housing could range from one to six years depending on where in Ontario an individual lived.

Another study performed by a team of seven researchers from four Ontario institutions in 2005 indicated that the mental-health housing sector lacked systematic and reliable data sources and a monitoring strategy, based on outcomes, to manage and improve housing stock and supports and to support policy development. The study also noted that the sector did not have the data needed to

determine the number and types of new units that should be created.

Levels of Service

While the Ministry has implemented a number of new supportive housing units, there is a mismatch between the care clients require and what they actually receive, which points to the need for better assessment and planning processes, and for more housing and support options. The 2004 report from the Comprehensive Assessment Projects of the Centre for Addiction and Mental Health noted that services in the community-mental-health system related to housing were not allocated on a rational basis.

Even when people with mental-health problems were able to find housing, they often did not receive the appropriate level of housing supports in the community to meet their needs. On the one hand, there was an oversupply of supervised housing. Of those in settings that provide a high level of support 24 hours a day, only 14% were identified as requiring that level of support. On the other hand, the needs of one-third of clients who required more intensive community support were not being met.

Housing Distribution and Vacancy Rates

Supportive housing units are unevenly distributed across the province. A research report issued by the Centre for Addiction and Mental Health in 2005 noted that “there is an inadequate supply of housing programs, evidenced by long waiting lists. Availability across the province is uneven, with higher concentrations of programs and supports in certain areas.” The Ministry indicated that some areas had more housing limits because certain initiatives targeted urban centres where homelessness was a major problem. While the Ministry has utilized housing allocation models in recent years to try to address historical uneven distribution, our analysis of the number of housing units each LHIN has relative to its population showed that:

- The distribution of supportive housing varied widely among the LHINs, ranging from a high of 273 units per 100,000 population in one LHIN to a low of 20 units per 100,000 people in another.
- Three LHINs each accounted for 9% of the provincial population, yet the number of housing units associated with each of them varied significantly. One had 32% of all housing units in the province, while each of the other two had only about 5%.

Although supportive housing is generally inadequate in Ontario, we found unusually high vacancy rates in certain areas. The Ministry allows the housing providers to budget for a 3% vacancy rate each year. However, on the basis of our review of 2006/07 vacancy rates and the costs of 10 housing providers, we noted that some housing providers were having difficulty filling their housing units:

- The 10 housing providers we reviewed incurred about \$1.1 million in vacancy costs and had an average vacancy rate of 8%.
- Vacancy rates and costs were especially high for two housing providers in the Greater Toronto Area. Their total vacancy costs were about \$860,000, based on the housing providers' year-end reports, which had not been reviewed by the Ministry at the time of our audit. Also, their respective vacancy rates were 26% and 14%—substantially higher than the Ministry's target rate of 3%. The Ministry informed us that the high vacancy costs and rates were mainly attributable to the Service Enhancement initiative that was still in its implementation phase. Therefore, it would take time for these two housing providers to fill up the housing units.

One-time Capital Funding

The Ministry provides housing providers with one-time funding for their capital reserve fund, both for specific repair work and for future capital repair needs at their housing sites. In the 2006/07

fiscal year, the Ministry paid \$11 million for one-time capital reserve funding. Within the areas covered by the seven former regional offices, we selected one housing provider from each region that received the greatest amount of one-time funding. Our review of the seven files found a number of examples where the funding was not used in a timely and cost-effective manner.

In one example, a housing provider purchased 15 units in two apartment buildings in 2003 for about \$1.6 million (about \$105,000 per unit) with a capital grant of about \$1.8 million provided by the Ministry. The difference between the purchase price and the capital grant (about \$270,000) was initially provided for renovation and consulting costs for the two buildings. Prior to the purchase, ministry staff reviewed an inspection report prepared by an independent consultant and conducted a walk-through of the units. The Ministry confirmed that the units were in fair condition, requiring some minor repairs and renovations, which were estimated by the independent consultant to be less than \$200,000. However, in 2007, the housing provider still had not started the renovations, and tender documents indicated that about \$780,000 would be needed for renovations to the 15 units and common areas. Specifically:

- Up to five of the 15 units were not repaired in a timely manner.
- Our review of the file indicated that the five units had been vacant for two to five years owing to their uninhabitable condition. Leaving these units unoccupied was particularly problematic because they are located in the LHIN that has the lowest percentage of supportive housing units relative to its population.

In another example, a housing provider requested \$68,000 in 2006, based on a quote from a contractor, to fix water leakage and mould problems in the basement of a house. Ministry staff conducted a site inspection and found the quote to be reasonable. As a result, in early 2007, the Ministry provided \$71,000 and advised the housing

provider to use the extra \$3,000 to hire an engineer to investigate the issue further. At the time of our audit, the repairs had not started. On March 31, 2008, the Ministry advanced an additional \$50,000 to the housing provider for the purpose of “further investigation into water penetration, damage to the foundation walls and ongoing repairs.” We have three main concerns:

- The \$71,000 initially provided by the Ministry was sufficient to cover both the cost of repairs (\$68,000) and building audit (\$3,000), and the Ministry had no documentation to support the additional funding of \$50,000.
- In addition, \$50,000 was an unreasonable amount for updating a previous assessment done only two years ago. Ministry staff told us that the \$50,000 was an arbitrary amount allocated because money from the one-time capital fund was available and had to be disbursed before the end of the 2007/08 fiscal year. The Ministry told us it wanted the housing provider to have additional funds in case more work was required upon completion of the audit.
- Aside from financial issues, at the time of our audit there had already been a one-and-a-half-year delay in starting the repair work in the basement, which was serving as a common area for the residents. The main reason for the delay was that the housing provider was deciding whether to sell the property, which was very old and becoming costly to maintain.

RECOMMENDATION 4

To ensure that adequate supportive housing is available to provide people with serious mental illness with appropriate, equitable, and consistent care, the Ministry of Health and Long-Term Care and the Local Health Integration Networks should:

- improve data-collection mechanisms and system monitoring to determine the number and type of housing units needed; the areas

with serious shortages of housing; the levels of unmet needs, occupancy and vacancy; and the adequacy and appropriateness of care provided to housing clients; and

- ensure one-time capital funding is being spent in a timely and prudent manner.

MINISTRY RESPONSE

Over the last four years, a total of 2,250 new supportive units have been implemented with a budget of approximately \$36.5 million. The allocation approach to these new units was based on areas of the province with high population growth and high demand, considering the current distribution of existing supportive housing.

The Ministry will continue to work with the LHINs to ensure that capital funding for projects being undertaken by LHIN health-service providers is used in a timely and prudent manner.

The LHINs have been mandated to plan for the health needs of their communities, including those with mental-health issues. The majority of LHINs have identified the need to address mental health as a priority. An important part of the local planning process will be to identify needs for supportive housing, as well as determining an appropriate mix of housing to meet the needs of people with mental illness within the LHIN.

As well, to support the LHINs' efforts to achieve their mandate to plan for the health needs of their communities, including those with mental-health issues, the Ministry will continue its work to incorporate demographic and other data related to mental health into the new Health Based Allocation Methodology initiative.

LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

Supportive affordable housing is the cornerstone of cost-effective community care for people with mental illness. The LHINs need to document

local variations in appropriate housing stock, and to work with the Ministry and various levels of government to ensure an adequate supply if the strategy is to succeed. As identified in the report, local monitoring of funds brought into the community to develop and maintain housing stock needs to be improved.

PROGRAM STANDARDS

As an increasing number of people with serious mental illness receive services in the community, it becomes all the more important that there be measurable and meaningful program standards to ensure that client needs are adequately met and that the services provided represent value for money spent. Standards set expectations for program requirements, such as staff qualifications and staff-to-client ratios, so that the services are delivered uniformly across the province and incorporate evidence-based practices (that is, practices that are supported by research findings and/or demonstrated as being effective through a critical examination of current and past practices). As was the case in our last audit in 2002, the Ministry had not developed standards defining acceptable services and service quality for the vast majority of the programs funded. Without such standards and criteria, it is difficult to assess whether people with serious mental illness are receiving the level and quality of services they require.

Programs with Provincial Standards

Currently, provincial standards only exist for assertive community treatment teams, intensive case management, and crisis intervention. Even though standards exist for these programs, we found that neither the Ministry nor the LHINs were monitoring the level of services actually being provided against these standards. A number of service providers we visited told us that neither the Ministry nor LHINs

monitored the service providers' implementation of standards. They told us that in the past five years, no staff—whether from the Ministry, from a former ministry regional office, or from a LHIN—had contacted them for monitoring purposes.

Assertive Community Treatment Teams

Assertive Community Treatment (ACT) teams are an alternative to hospitalization for people with serious mental illness. ACT teams provide ongoing, individualized, intensive support, helping clients develop the skills they need to live in the community. In the ACT model, a multidisciplinary team provides a full range of services to a roster of clients (about 80 to 100). Each team usually comprises 9 to 12 full-time clinical staff, including a psychiatrist, registered nurses, a program assistant, a team co-ordinator, and, at a minimum, a social worker, occupational therapist, substance abuse specialist, vocational specialist, and other specialists. ACT team services are available around the clock, seven days a week.

The Ministry began to implement the ACT model across the province in 1998. As of March 2008, there were 79 ACT teams in Ontario, compared to 60 at the time of our 2002 audit. The Ministry developed provincial ACT standards in 1998 and revised them in 2005. The standards describe staff requirements, program organization and operations, admission criteria, and service capacity and components.

In March 2008, the Ministry released its report covering the activities of the 72 ACT teams during the 2006/07 fiscal year. According to this report, there were about 4,500 clients registered with ACT teams across the province, and the average caseload for ACT teams was 63 clients, which was below the targeted caseload of 80 to 100 clients per team. Our review of ACT information in the Ministry's database showed that the staff-to-client ratio per team ranged from 1:0.4 to 1:14, indicating that some teams had more than two staff for each client served while others had only one staff member

per 14 clients. Our discussion with ministry staff indicated that:

- They were unable to ensure the accuracy and reliability of data provided by the ACT teams because ACT data are self-reported and the community-mental-health sector is relatively new to data reporting.
- With unreliable data, they were unable to measure the performance of each ACT team against the standards by compiling statistics such as staff-to-client ratio per team, funding per team, enrolment capacity per team, and wait times per team.

When the Ministry developed the initial ACT standards in 1998, it also set up a voluntary Technical Advisory Panel, with the purpose of providing technical information for developing and implementing programs. The panel, which meets four times a year, includes representatives from ACT teams in each area of the province, as well as family organizations, clients, the Psychiatric Patient Advocate Office, and senior ministry staff. Panel members indicated that there is no mechanism for monitoring compliance with ACT standards. The Ministry indicated that over the past two years, the Ministry and the panel created orientation and training sessions for new teams as well as teams that were experiencing challenges.

We noted that in 2001, the Ministry had a technical support group with two senior clinicians to assist in implementing standards, educating and training teams, reviewing team functions, and developing a future ACT monitoring and compliance-assessment process. However, the Ministry informed us that it had disbanded the group owing to limited funding.

Intensive Case Management

Another program with provincial standards is intensive case management (ICM), which promotes independence and quality of life through the coordination of appropriate services and the provision of constant and ongoing support as needed by the

clients. Individual case managers provide outreach, assessment, planning, and advocacy, and they link clients with other treatment and rehabilitation services, such as social recreation, employment programs, and supportive housing. Unlike ACT, intensive case management does not typically provide round-the-clock service.

The Ministry developed standards for ICM in 2005, but has not yet monitored service providers' performance against the standards. For example, ministry staff indicated the Ministry cannot monitor such standards as "case manager-consumer ratio of no more than 1:20 must be maintained," "service provision must be focused in the community not in the office," and "services must be available a minimum of eight hours/day, five days a week," because its information systems do not collect data on the number of case managers, location of service provision, and frequency and duration of client contacts. Neither the Ministry nor the LHINs conduct any site visits to assess program delivery.

Programs with No Provincial Standards

The following programs, which served about 10,000 clients across the province in 2006/07, are indicative of the majority of community-mental-health programs for which the Ministry has not developed provincial standards.

Short-term Crisis Residential Beds

Short-term crisis residential beds ("safe beds") are used for temporary emergency shelter as an alternative to incarceration or hospitalization. Service is provided for people with serious mental illness who are in crisis or have come in contact with the law. People remain in the safe-bed setting for a short period while linkages and referrals are made to other community programs. The cost per bed is about \$85,000 per year. At the time of our audit, we noted that:

- The Ministry had not developed standards to specify where these beds should be located

and what qualifications staff monitoring the beds should have. Some beds were located at various sites including a motel, a private home, and on the main floor of an apartment building.

- The Ministry's information systems did not maintain data on the number of beds available in the province and the length of time the beds were occupied. This lack of data hampered the Ministry's ability to monitor whether the demand for such services was being met and the impact of the services on the mental-health system.

Ministry staff agreed that there is a need to ensure that the beds committed by service providers have indeed been set up and services are being provided to the correct population.

Community Treatment Order

In 2000, the government introduced legislative changes to ensure that people with serious mental illness get the care and treatment they need in a community-based system. The new legislation established that a certified physician may issue a Community Treatment Order (CTO), which provides an individual with community-based treatment or care and supervision that is less restrictive to the person than being detained in a hospital environment. Individuals with a CTO are required to comply with the order to report to a physician every six months. There were 975 CTO clients as of November 2007. A review of the CTO program conducted by an external consultant for the Ministry in 2007 noted that:

- Although the CTO program had been in place for over seven years, the Ministry still had not developed standards for CTO co-ordinator positions, provided a common job description for CTO co-ordinators, or defined roles and responsibilities for parties involved. Thus, there was no assurance of service consistency.
- The Ministry designed forms, set up mechanisms for collecting data, and developed a

database for CTO information, but has not designated anyone to manage and maintain the data. Thus, the Ministry has not produced any systematic analysis or reports that would facilitate CTO monitoring. Some CTO co-ordinators have stopped submitting data because they never received any feedback from the Ministry and realized that the Ministry likely did not use the information.

Early Intervention in Psychosis

The Early Intervention in Psychosis Program aims to reduce the severity of untreated psychosis and to increase the likelihood of recovery through early and appropriate detection and response. The first onset of a psychotic illness usually occurs between the ages of 15 and 34. Because the program is a relatively new approach to mental-health care, the key components for effective and efficient operation have not yet been put in place. For example:

- At the time of our current audit, the Ministry was still in the process of developing program standards. It had created a policy framework in 2004, but that framework merely assists service providers in planning and developing programs—it does not set standards.
- The policy framework defines the priority population for early intervention services as those people between the ages of 14 and 35, but we found that this policy was not consistently applied. We selected five service providers and reviewed their admission requirements. Our review found that the majority of service providers accepted only those clients who were older than 15. Thus, the youngest segment of the priority population (ages 14 to 15) is at risk of not being served by either the child or adult mental-health service providers, creating a potential service gap.
- The Ministry will need to establish performance and outcome measures, monitoring mechanisms, and evaluation systems to

enable it to assess the success of this new program and identify effective practices to communicate to LHINs and service providers.

RECOMMENDATION 5

To ensure that service providers are delivering comprehensive, consistent, and high-quality services in a cost-effective manner across the province, the Ministry of Health and Long-Term Care and the Local Health Integration Networks should:

- improve data-collection mechanisms and reporting requirements to obtain relevant, accurate, and consistent information across the province for performance monitoring purposes; and
- establish provincial standards, performance benchmarks, and outcome measures for at least the more critical programs against which the quality and costs of services can be evaluated.

MINISTRY RESPONSE

In accordance with the ministry mandate for establishing provincial policy and program standards, the Ministry will establish standards for early psychosis intervention and short-term crisis beds.

The Ministry will also be focusing on existing data-quality issues, including the provision of education related to data standards to both data providers and users.

The Ministry will utilize its data and organized reporting structure, such as the mental-health scorecard, to establish performance expectations and benchmarks in collaboration with the LHINs and stakeholders. The LHINs will work with the health-service providers to improve their compliance with these requirements and will utilize the measures to monitor service providers. It is expected that new standard dashboards for the Ministry, LHINs, and agencies will be created by 2010.

LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

The report highlights the need for program standards and to measure health-service-provider ability to meet the standards. The LHINs appreciate the need to work with the Ministry and experts in the field to establish appropriate standards and measures for care and treatment. This will facilitate the LHINs' ability to monitor the service provider, and to determine local needs, priorities, and strategies as well as improvements required to increase accessibility, co-ordination, and capacity.

PERFORMANCE MEASUREMENT AND REPORTING

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 are quantifiable measurements, established beforehand, that reflect the critical success factors of a program or service. They provide a meaningful method for measuring and reporting on progress in achieving objectives. Good performance reporting should include the following attributes:

- clear goals and objectives;
- complete and relevant performance measures;
- appropriate standards and targets for measuring results;
- reliable systems for gathering the necessary information; and
- a reporting mechanism for regularly communicating accomplishments and areas requiring corrective action.

Information of this nature would enable the Ministry to make more informed decisions about funding and other matters.

Mental-health Scorecard

In our *2002 Annual Report*, we noted that the Ministry had limited information about whether community-mental-health resources were being used efficiently and effectively. Since then, the Ministry has initiated processes to develop performance indicators to measure community-mental-health services and outcomes. In January 2007, the Ministry rolled out its Mental Health Strategy Map and Mental Health System Scorecard to create strategic alignment and improve performance. The strategy map articulates a mission, strategy, and goals while the scorecard defines a set of performance indicators and measures. By linking the strategy map goals with the scorecard, the Ministry gains a better understanding of what it needs to do to improve performance, achieve desired outcomes, and increase accountability.

Although the scorecard identifies 29 indicators, we found that about half of them were not ready for full implementation for the following reasons:

- Data sources have not been available for some indicators, such as the availability of co-ordinated intake/access processes, family satisfaction with services, and use of electronic referral and tracking mechanisms.
- Data used for some performance indicators were either incomplete or of poor quality. This included availability of resources for information management, human-resources capacity, wait times, as well as client-outcome information such as criminal involvement, employment rate, and financial status. Data were incomplete because many service providers did not provide data. Data from service providers that did provide information were often of poor quality and unusable because of the service providers' confusion about the interpretation of data definitions, such as “wait times,” and about reporting requirements.

In addition, the Ministry has not determined performance indicators to measure critical aspects of program delivery such as responsiveness to client

needs, sustainability, and equity in the mental-health system, client continuity of care, and clinical outcomes. We also noted that the Ministry still has not developed measurable and meaningful targets or benchmarks for each performance indicator, despite our having identified this need in both our *1997 Annual Report* and *2002 Annual Report*. In both 1997 and 2002, the Ministry indicated that it was developing targets or benchmarks based on best practices for mental-health services. Yet in our current audit—11 years after we first raised the issue—we found that no target or benchmark has been determined. The Ministry acknowledged that the availability of performance targets or benchmarks is still very limited. This hampers its ability to measure and compare performance between service providers.

The Health System Performance Research Network (Network), known as the Hospital Report Research Collaborative (Collaborative) prior to 2008, is a network of university-based researchers working on projects to identify, validate, implement, and exploit performance information of value to the health system in Ontario. In 2004, the Collaborative noted that the mental-health sector had very sparse performance reporting. A study by the Network in 2008 mentioned that “there has been very little performance measurement activity in the community-mental-health sector, and as a consequence, the field is relatively naïve in this area.”

The recent Mental Health Strategy Map and Mental Health System Scorecard are good initiatives. However, performance measurement—that is, assessing how effective a program is in meeting the needs of people with mental illness—still needs significant improvement.

Information Systems

The effective management of large, diverse programs like community-mental-health services requires consistent data collection and reliable information systems. Service providers need timely

and accurate information to effectively manage their operations and promptly respond to client needs. The Ministry and the LHINs also need appropriate and relevant information to monitor the costs and utilization of services and the performance of service providers. Our last three audits of this area in 1987, 1997, and 2002, respectively, all noted the lack of an integrated client information system as a critical weakness.

Given this history, we are pleased to note that in 2003/04, the Ministry implemented two new systems to collect data for the community-mental-health sector: the Management Information System (MIS) and the Common Data Set-Mental Health (CDS-MH) system. The MIS collects financial and statistical data from service providers on a quarterly basis. It reflects the requirements of Ontario Healthcare Reporting Standards, which provide the framework for improving consistency in the reporting of financial and statistical information by service providers. The CDS-MH captures administrative and clinical data from service providers twice yearly. It is a uniform data set that collects aggregate client information on wait times, service utilization, and outcome measures. The CDS-MH does not yet maintain any client-level data, such as the age, gender, or condition of individual clients.

Our review of these two systems indicated that 80% to 90% of service providers are now submitting data and complying with the reporting requirements. Notwithstanding, ministry staff did indicate that the nature of some mental-health service providers made information collection and management difficult owing to lack of expertise and resources. These service providers expressed difficulty in meeting the reporting timelines. The service providers we visited indicated problems in data reporting, including a lack of resources and ministry support, no standardized data collection tools, and not knowing exactly when and how they should report certain types of data for which definitions are not clear, such as wait times. The Ministry indicated that it has now fully documented the data definitions and distributed them to the providers.

Our review of information produced by the systems indicated a number of unusual or unreasonable results that we would have expected the Ministry to have followed up on. For example:

- One service provider reported over 17,000 people waiting for case management services while others reported fewer than 150.
- The cost per service recipient for crisis intervention varied widely between service providers, ranging from \$11 to \$590,000, while the provincial average was about \$280.
- About 100 service providers reported zero or even negative administrative expenses.

These examples indicated that, although service providers are doing a better job of submitting data, the quality of the data and the data's usefulness in decision-making need improvement. The Ontario Health Reporting Standards manual states that "the Ministry will run trend reports and comparative indicators reports and share these with health service representatives to identify data quality issues. Organizations with unusual values will be contacted to determine the source of the variance and correct the data if appropriate." The Ministry/LHIN Accountability Agreement also states that "the Ministry will conduct routine data timeliness and quality checks on data and information as it is submitted by service providers, including contacting service providers on behalf of the LHIN about late reports, missing data, and inconsistent data; measuring the timeliness and quality of data submitted by service providers; and providing reports to the LHIN when there is an issue with data timeliness and quality submissions by service providers."

Although the Ministry has documented the data review process well, it does not review the information received to identify data anomalies or outliers or to assess the reasonableness of the data. At the time of our audit, the Ministry was sending emails to the LHINs and service providers only about missing data and late reports. Our discussions with ministry staff confirmed that they have no formal process to review data quality in the community-mental-health sector. The Ministry told us that data

quality review is on the list of outstanding items for the mental-health sector and a plan is to be rolled out by summer 2008. It also intends to produce standard data quality reports for the community-mental-health sector in the 2008/09 fiscal year.

Our review also showed that, unlike the situation in the addiction sector, no client-level information is available in the community-mental-health sector because the CDS-MH only accommodates the secure collection of aggregate data. This means that the Ministry is only able to track the progress of a group of people rather than an individual over time. The Ministry indicated that, in the future, it will need to develop systems infrastructure to support the collection of client-level data to enable it to assess the extent to which the needs of these clients are being met effectively.

We noted that a new tool, the Camberwell Assessment of Need (CAN-C), is being used in certain other jurisdictions to track client-level data and assess the health and social needs of people with mental illness. We were advised that CAN-C was being deployed in 16 pilot sites across the province at the time of our audit. However, the Ministry had made no decision about the appropriate level of system support and whether to fully implement CAN-C province-wide. A decision about province-wide rollout will be made following evaluation of the pilot projects by the end 2008/09.

RECOMMENDATION 6

To better enable it to assess whether the service providers are delivering services in a consistent, equitable, and cost-effective manner, the Ministry of Health and Long-Term Care should:

- complete implementation of its comprehensive set of performance indicators and select targets or benchmarks that will enable the Ministry and Local Health Integration Networks to properly assess the performance of service providers;
- improve information systems to enable them to collect complete, accurate, and useful data

on which to base management decisions and to help determine if services provided are effective and represent value for money spent; and

- report periodically to the public on the performance indicators for the community-mental-health sector.

MINISTRY RESPONSE

The Ministry continues to work on refinement of performance indicators related to the mental-health sector. The current Ministry/LHIN Accountability Agreement includes two developmental indicators related to mental-health services. Over time, the Ministry expects that these indicators, and potentially others, will be used to assess the LHINs' performance with respect to mental health.

The LHINs are currently in the process of developing the new accountability mechanisms that will apply to the mental-health sector. The proposed Service Accountability Agreement provides for the LHINs to conduct periodic reviews of the health-service providers.

With respect to improvements to information systems, the Ministry and the LHINs currently have a mutual obligation to identify and discuss data and information gaps, information-management requirements, and data quality issues. Standards relating to the two information systems are documented and posted online for users to access. As well, the submission processes are also fully documented and available online for users to access. The Ministry will improve its data timeliness and quality checks and the LHINs will work with the health-service providers to improve their compliance with these requirements.

LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

The mental-health sector lacks robust performance measures and, historically, reporting has been inconsistent. The time has come to make a concerted effort within an established time-frame to develop an evidence-based scorecard that is feasible for programs on tight budgets to administer. The Ministry needs to work with content and methodological experts to assure this exercise is complete. This is a precondition if the LHINs are to have the required tools to carry out their mandate.

MONITORING AND ACCOUNTABILITY

Regular monitoring of all community-mental-health services is the basis for program accountability and for continuous quality improvement. In *Making It Happen*, the Ministry “committed to the principle of greater accountability in the reformed mental health system.” As Crown corporations, the LHINs are responsible for managing local health system service providers on behalf of the Ministry. It is therefore critical for the Ministry to have appropriate monitoring mechanisms in place. Ultimately, all the system partners—the Ministry, the LHINs, and service providers—are jointly accountable to all Ontarians for meeting the needs of the mentally ill.

Monitoring of LHINs

Under the new organizational structure, the Ministry allocates funding to the LHINs, which in turn assign funding to the service providers. A Memorandum of Understanding and a Ministry/LHIN Accountability Agreement govern the relationship between the Ministry and each LHIN. This agreement includes performance goals and objectives, performance standards, targets and measures, and a plan for spending money. The LHINs enter

into contracts called Service Accountability Agreements with all service providers to ensure that there is a mutual understanding of the services to be provided. However, we found specifically that the Ministry required each LHIN to develop an Integrated Health Services Plan (IHSP) for the three-year period from 2007 to 2010. The IHSP is a strategic plan that includes a vision statement, strategies, and specific priorities for the local health system that reflect the health status of the local population and identify areas of focus. However, ministry staff indicated that while the Ministry was not required to approve the IHSPs, they monitored the LHINs' accomplishment of their stated priorities through the Ministry and LHINs' Memorandum of Understanding and Accountability Agreement.

We reviewed the IHSPs and Annual Services Plans (ASPs) of the LHINs we visited and noted a number of critical issues and risks identified in these documents. Examples of such critical issues and risks are the significant wage disparities between the community and institutional sectors, the risk that service volumes will be reduced owing to inadequate increases in base funding, the failure to move the mentally ill from hospitals to a more appropriate level of care, service gaps in supportive housing, and the absence of new funding to support co-ordination and access initiatives.

Monitoring of Service Providers

Service Accountability Agreements

The primary method of holding the service providers accountable is signed service agreements that stipulate reporting requirements and bind service providers to achieve specific, measurable results. The existing agreements between the Ministry and service providers are to continue until the LHINs negotiate new Service Accountability Agreements with their service providers. The Ministry is phasing this in gradually. For the community-mental-health sector, negotiations for the new agreements will take place in the 2008/09 fiscal year, with

the agreements coming into effect April 1, 2009. These new agreements are to include performance schedules, which allow the LHINs to measure performance expectations of the service providers. However, at the time of our audit, the LHINs had not yet devised these performance schedules.

Operating Plans

The Ministry also monitored community-mental-health services by reviewing annual operating plans and budgets submitted by the service providers. The operating plans describe community-mental-health programs, goals and objectives, targets and outcomes, human resources, financial initiatives, proposed changes, and new developments. The operating plans are important for the Ministry and the LHINs to understand the operations of service providers and to determine if services are being provided with due regard for efficiency and effectiveness. The operating plans, together with the budgets, specify the projected costs of service delivery and administration. Prior to the transfer of authority to the LHINs, the Ministry reviewed each operating plan and gave final approval once satisfied that the funding is to be used to provide the appropriate services.

We reviewed a sample of 2006/07 operating plans and assessed the Ministry's review of them and noted three issues. First, the operating plans varied significantly in the quantity and quality of supporting information included. About half of the plans did not provide all the information required by the Ministry, and there was no evidence that the Ministry followed up on the missing information. Second, ministry reviewers were not consistent in how they reviewed the plans. Third, the Ministry did not provide feedback in a sufficiently timely manner to enable service providers to rectify any issues identified; it took an average of 103 days for the Ministry to get back to service providers, although we were advised that ongoing discussions did take place between the Ministry and service providers during this time.

In addition, the service providers we visited saw the operating plans as the main vehicle of communication with the Ministry on their operational results and financial pressures. As such, the operating plans are an important means for the Ministry and the LHINs to gain an understanding of and monitor service providers' operations, particularly given the limitations of the performance indicators reported to date. However, as of the 2007/08 fiscal year, service providers were not required to submit operating plans to the Ministry or the LHINs. Eliminating the valuable quantitative and qualitative information that the operating plans provide will hamper the Ministry and LHINs in their ability to monitor and evaluate the performance of service providers and to ensure that clients are receiving effective and high-quality services.

Other Monitoring Issues

We also noted several other deficiencies related to the monitoring of service providers:

- Former regional office staff told us that they monitored program accountability through quarterly financial reports, annual operating plan reviews, and phone discussions. On asking for documentation or evidence of such reviews, the Ministry advised us that, owing to the closing of the regional offices in March 2007, its records of monitoring activities on service providers were not available.
- Although the LHINs are now responsible for monitoring service providers, none of the LHINs we visited had performed any monitoring except for budget review. At the time of our audit, there was no compliance monitoring in the community-mental-health sector. LHIN staff told us that they had limited expertise and resources in the mental-health area to perform the monitoring function.
- According to the Ministry/LHIN Accountability Agreement, in 2007/08 the Ministry and the LHINs were to jointly develop guidelines

for the LHINs on conducting audits, inspections, and reviews of service providers to ensure consistency among the LHINs. However, at the time of our audit, these guidelines were not yet available for the community-mental-health sector. Ministry staff indicated that they were still working with the LHINs to develop such guidelines.

Monitoring and Recovering of Funding Surpluses

Service providers are required to report their revenues and expenses by submitting settlement packages each year. A complete settlement package includes audited financial statements, a signed auditor questionnaire, and a variance explanation form. It gives the Ministry assurance over the financial information submitted by the service providers. Similarly, housing providers are required to submit an Annual Information Return (AIR), which reports their financial, operating, and statistical information. Review of the AIRs determines if the funding provided was reasonable, and if the housing providers' spending practices adhered to program requirements.

The Ministry requires that all surpluses or unspent funds be returned to the government at the end of the fiscal year. Although the Ministry has a formal settlement process for collecting surpluses owed by the service providers and housing providers, it has been unable to complete this process on a timely basis. The Ministry has recognized that outstanding settlements are an issue and has made progress in addressing this problem. However, at the time of our audit, there remained a significant backlog of settlements yet to be cleared. Figure 7 shows the proportion of all service providers and housing providers with incomplete settlements from the 2002/03 fiscal year through 2006/07 as of March 2008.

As Figure 7 illustrates, outstanding settlements date back several years and are particularly high for

Figure 7: Incomplete Settlements From Service and Housing Providers, 2002/03–2006/07 (%), as of March 2008

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

	Community-mental-health Service Providers	Housing Providers
2002/03	1	35
2003/04	4	41
2004/05	5	44
2005/06	12	77
2006/07	74	99

housing providers; in most cases, there have been no settlements made with providers for the last two years. Ministry staff indicated that inadequate staffing was the main reason contributing to the backlogs. We estimated that the Ministry would have recovered at least \$13 million if all settlements had been reviewed.

Monitoring of Third-party Contracts

A service provider may act as a distributor of funds for the Ministry to a third party, such as another service provider or external organization that might not have a funding and reporting relationship with the Ministry. This can create a weakness in accountability. We are generally not satisfied that proper accountability measures are in place for monitoring such third-party contracts. Specifically:

- The Ministry was unable to provide a complete list of service providers involved in third-party contracts and the actual amounts provided to them.
- The Ontario Healthcare Reporting Standards manual stipulates that the Ministry will reconcile funding flows to third parties each year to ensure correct reporting of these funds. However, we found that no area of the Ministry was performing these reconciliations.
- Third parties with no direct reporting relationship with the Ministry are required to

report financial and operational data to the service provider, which will then report such information to the Ministry for monitoring purposes. However, we found that this was not an established practice. One service provider we visited indicated that it was not aware of this requirement, had not collected financial and operational data from the third parties it funded, and thus had never reported this information to the Ministry on behalf of the third parties. Our review showed that over \$1 million flowed annually from this service provider to various third parties.

- The Ministry could not be assured that funds provided by service providers to third parties were spent for the intended purposes. For example, our review showed that one service provider had provided \$1.2 million to a third party for community-mental-health services. However, our follow-up research of the third party indicated that its business was confined to substance-abuse services—not community-mental-health services—indicating that the \$1.2 million was probably not being spent on the purposes intended.

RECOMMENDATION 7

To ensure that all partners in the community-mental-health sector—the Ministry, the Local Health Integration Networks (LHINs), and the service providers—are accountable to Ontarians for the effectiveness and quality of services, the Ministry should:

- develop compliance mechanisms to monitor the LHINs' accomplishment of their stated priorities and provide feedback to the LHINs for improvement of their operations; and
- review settlement packages on a timely basis to ensure that funding is being spent in accordance with ministry guidelines and that significant funding surpluses are being recovered from service providers.

The Local Health Integration Networks should:

- develop guidelines together with the Ministry on monitoring service providers, which include requirements to monitor significant third-party contracts and to ensure that community-mental-health funding is being well spent.

MINISTRY RESPONSE

The *Local Health System Integration Act*, the Ministry/LHIN Memorandum of Understanding, and the Ministry/LHIN Accountability Agreement contain a number of requirements related to LHIN accountability. Currently, the LHINs report quarterly to the Ministry and provide an annual report to the Legislature.

The Ministry reviews the LHINs' reports against the above requirements, monitors the LHINs' accomplishments of the performance indicators contained within the agreement, and

provides regular feedback to the LHINs on these reports.

With respect to outstanding settlement packages, the Ministry has recovered approximately 50% of the backlog and expects to have all outstanding settlements, up to and including the 2006/07 fiscal year, completed by March 31, 2009.

The LHINs are responsible for managing their local health-service providers including appropriate methods to monitor third-party contracts.

LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

If the LHINs are to carry out the all-important monitoring and accountability function of their mandate, the necessary tools need to be developed and at hand. The LHINs and the Ministry need to assess the current status, and to determine what is necessary to move ahead.